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ABSTRACT

This guide for teachers whose classes include a medically fragile child considers roles and responsibilities of teachers with these students, teachers' rights as school employees, and possible solutions and protections for local unions to pursue. Chapter 1 provides an overview. It defines "medically fragile," summarizes legal requirements under federal law, and presents the position of the American Federation of Teachers (AFT) that teachers should not be the primary service providers of health care services to these children. Chapter 2 considers the role and responsibilities of the school nurse as well as legal considerations for the school nurse. Chapter 3 raises legal issues about medically fragile children such as the importance of complete and confidential school records, liability issues for school personnel including school nurses, and "Do Not Resuscitate" orders. Chapter 4 details the roles of non-nursing school personnel including the teacher, the paraprofessional, bus drivers, and others. Chapter 5 raises such health and safety issues as communicable diseases and chapter 6 gives practical suggestions for coping in the classroom. Chapter 7 offers examples from union contracts which address specific concerns. Among nine appendices are AFT policy statements, position papers from non-AFT organizations, sample state legislation, a summary of State Nurse Practice Act provisions, a directory of State Boards of Nursing, and sample forms and letters. (Contains 25 references.) (DB)

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The Medically Fragile Child in the School Setting

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American
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EC 306464

The Medically Fragile Child in the School Setting

Second Edition

American
Federation
of Teachers

This manual was produced by the AFT's Ad Hoc Committee on Health Care Responsibilities in Special Education. It represents the joint efforts of the AFT's Educational Issues Department, the Federation of Nurses and Health Professionals and the Paraprofessional and School Related Personnel Division

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Foreword

Children deserve the best possible education in the safest possible environment. It is our responsibility, as members of the education team, to provide both. The influx of medically fragile children into our schools has complicated this responsibility. As teachers, paraprofessionals, school nurses, or any other worker in the school, we are torn between our responsibility to students and our concern about duties we may not be adequately prepared or legally allowed to take on.

The AFT heard these concerns and responded to this dilemma by creating the Ad Hoc Committee on Health Care Responsibilities in Special Education. This committee was a joint effort of the AFT's Educational Issues Department, the Federation of Nurses and Health Professionals, and the Paraprofessional and School Related Personnel Division. The work of this committee resulted in the first edition of the *Medically Fragile Child in the School Setting*. Part of the work of the committee was continued by the AFT's Task Force on Special Education. Its recommendations have resulted in the second edition of the manual. As before, this book has a two-fold purpose. It should be used as a resource to educate members on their roles and responsibilities with students **and** their rights as school employees. Second, it outlines possible solutions and protections for local unions to pursue on behalf of their members.

Our research indicates that the challenge of providing services for medically fragile children in the school setting will continue to grow. We must be prepared to meet this challenge, serve our students, and protect our members. We believe that this resource guide is the first step.

In unity,

LORRETTA JOHNSON
AFT Vice President for PSRP

CANDICE OWLEY
AFT Vice President for FNHP

MARCIA REBACK
AFT Vice President and Chair, Special Education Task Force

Chapter 1

Overview: Medically Fragile Children

- Are you sympathetic to the drive to teach children with serious medical problems in conventional school settings, yet astounded that teachers and paraprofessionals now are expected to cope with such students without necessary nursing assistance, training, and resources?
- Do you find it incomprehensible that your school system is laying off or not hiring school nurses at the same time increasing numbers of new children with serious health impairments are being enrolled?
- Do you know teachers and paraprofessionals who feel legally vulnerable because they are being asked to perform nursing procedures for these medically fragile children?
- Do you worry that the education of other students might suffer because of the inordinate amount of time teachers and paraprofessionals are now giving to medically fragile children?
- Do you see the benefits of integrating most children with medical problems into typical school settings but just wish it could be done properly and appropriately on a case-by-case basis?

Who and Where Are the Medically Fragile Children?

Medically fragile children are "students with specialized health care needs that require specialized technological health care procedures for life support and/or health support during the school day. These students may or may not require special education" (CEC Ad Hoc Committee on Medically Fragile Students, March 1988). Medically fragile children have also been described as persons with complex medical care needs who require technology, specific services, or some form of ongoing medical or nursing support for survival.

The term "medically fragile" has a meaning similar to a chronic or acute illness, physical disability, or other health impairment that can be extremely disabling or life threatening, according to a report by the Great Lakes Regional Resource Center in 1986. This is distinguished from other health impairments because of the acuteness and severity of the problems that usually require prolonged or intermittent hospitalization, institutionalization, or home-bound placement. The report further states, however, that the uniqueness and severity of each child's disability require that his or her educational program be determined on a case-by-case basis.

The Medically Fragile Child: What the Law Requires

Public Law 94-142 and the Individuals with Disabilities Education Act (IDEA)

In 1975, the Education for All Handicapped Children Act, also known as Public Law 94-142, was passed. The law gave all students—regardless of physical or mental disabilities—the right to a "free and appropriate public education" (FAPE) in the "least restrictive environment" (LRE) appropriate to their needs. The "least restrictive environment" is defined as "to the maximum extent appropriate, children with disabilities...are educated with children who are not disabled; and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." P.L 94-142 set out a "zero-reject" policy; school districts cannot refuse to serve students no matter how severe or difficult to serve their disability might be.

The passage of P.L. 94-142 meant that large numbers of youth with physical or mental disabilities, who previously had been underserved or not served at all by the public schools, benefited tremendously. They were now entitled to an education provided by the public schools. Schools were suddenly faced with the task of providing sufficient placements, faculty, and resources to provide what the law required.

Recent amendments to the law, most notably the Individuals with Disabilities Education Act (IDEA) in 1990, have expanded the eligible student population to include preschool students. By September 1990, all 3-year-old children with disabilities had to be served by the public school system.

In order to be eligible for IDEA, a student must have one or more of the 13 disabilities listed in the statute and need special education and related services because of those impairments. Eligibility is determined by a multidisciplinary team, including at least one teacher knowledgeable in the area of the child's suspected disability. Once the student is declared eligible, an Individualized Education Program (IEP) is developed. The IEP contains, among other things, a statement of the specific special education and related services to be provided to the child and the extent to which the child will be able to participate in regular education programs. The IEP is a key document for the IDEA-eligible child: it is essentially a prescription for the instructional, related, and other support services that the school district must provide to the child.

Section 504 of the Rehabilitation Act of 1973

Section 504 protects the rights of persons with disabilities in programs and activities that receive federal funding. Under Section 504, no one with disabilities can be denied access to any program or activity that receives federal funds. According to Section 504, an individual with a disability is a person who has a physical or mental impairment which substantially limits major life activities, a person who has a record of such an impairment, or is regarded as having such an impairment. Major life activities include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. The term does not include an individual who is currently engaging in the illegal use of drugs.

All IDEA-eligible students are also covered by Section 504, but the reverse is not true. The population of Section 504-eligible students is much larger than the population of IDEA-eligible students and most students who are only eligible to receive services under Section 504 receive services and accommodations in a general education setting.

School districts receiving federal funds must provide a free appropriate public education to each student with disabilities, and ensure that each student with disabilities is educated with non-disabled students to the maximum extent appropriate to the needs of the disabled student. In this handbook we will focus on what the law means for students with significant health impairments-or "medically fragile children."

Changes in Where Services are Provided for Medically Fragile Children

Medically fragile children were cared for in hospitals or institutions until the 1980s. These institutions took care of their educational, developmental, and medical needs. However, recent federal, state, and local policies of deinstitutionalization and the movement for health care cost containment have put pressure on the medical insurance industry to reimburse families for medical expenses incurred when a patient is not hospitalized. Home health care, although costly, still is less expensive than hospital care. In addition, advances in health care technology have made it possible for children to leave hospitals and attend schools when previously they could not.

The Pressure for Inclusion

Advocates for students with disabilities believe that, whenever possible, disabled students should be deinstitutionalized and integrated into mainstream society. For children, this means attending school in the least restrictive environment. Such service settings might include regular classrooms; resource rooms; self-contained special educational classrooms in a regular school; special schools for mentally or physically disabled children; or when necessary, hospitals or institutions, depending on the level at which the child is able to function. IDEA and a number of state court decisions now give legal weight to the argument that more of these children should be in regular schools. This means that severely disabled students are entering public schools in unprecedented numbers. Children with disabling conditions and health care needs ranging from the simple to the most complex are being moved from institutions and special education centers and placed in regular schools.

What Are the Results?

As a result of the legislation about the education of disabled children and a number of court decisions interpreting its intent, many public school systems already provide such non-medical services as toilet training, diapering, assistance with feeding, and training students to perform these basic needs themselves. What we are seeing now is just the beginning. Advances in medical technology and procedures have led to higher survival rates for children with chronic illnesses and congenital abnormalities, as well as for victims of trauma. This means that today there are more children with long-term health care needs who often require expensive equipment to sustain them.

As a result of deinstitutionalization, drug and alcohol abuse by pregnant mothers that cause many babies to be born with anatomical and/or developmental abnormalities, teenage pregnancies that often give rise to premature or low birthweight babies, and the thousands of children born with AIDS every year, more and more children with chronic health care needs are entering the public schools. This places a strain on school resources that soon will become even more pronounced.

Some of the health care responsibilities now required of the public schools must be performed by state-licensed health personnel. Others require the training of non-licensed personnel and the use of special equipment. In some schools, employees are being assigned to suction mucous from the airways of children who can't do it themselves. School personnel also are being assigned to perform such tasks as caring for students who have special breathing apparatus, inserting catheters into the bladders of children who are unable to urinate, administering insulin or giving other injections or medications as required, and inserting feeding tubes for liquid nutrition. In some cases, emergency and resuscitative procedures must be established and practiced.

The placement of these medically fragile children in the public schools and the responsibilities for care these placements require have given rise to several areas of concern. These include the need for adequate funding, availability of appropriate facilities, new roles and responsibilities for school personnel, appropriate training, and legal and liability issues.

What about Funding?

IDEA gives public schools the primary responsibility for educating and providing school-related services to disabled children. When these children are deinstitutionalized and begin living at home, the private insurance companies and government agencies that previously provided health care services begin to minimize their services and shift the responsibility for these medically fragile children to the public schools. Public schools with already limited funds find that the cost of financing special education—already enormous—is soaring. To carry out this mandate, school districts need additional funds to hire specialized personnel and school nurses, provide technical equipment and additional transportation and, in some instances, to remodel facilities to accommodate the needs of the children, further stressing already financially strained budgets.

Can Facilities, Equipment, and Conditions Possibly Be Adequate?

Although profoundly disabled children with chronic health problems are entering the public schools in increasing numbers, the facilities and conditions under which many health-related procedures must be performed are woefully inadequate. For example, invasive procedures that require objects to be inserted into the body often are performed without training and in facilities lacking privacy, hot water, or other proper sanitary conditions.

What about Training?

Due to the decreasing numbers of nurses assigned to the public schools, there is inadequate training, supervision, and evaluation of the non-medical personnel who are required to perform these procedures.

Having to perform health-related procedures in less than optimal conditions places teachers, paraprofessionals, and other school-related personnel in a position where they possibly could jeopardize the health and safety of students.

What Are Appropriate Roles and Responsibilities for Non-Nursing Related School Personnel?

As non-nursing related school personnel are required to perform more health care procedures, concerns arise regarding job descriptions and requirements, school conditions and available facilities, staff training and competencies, and liability, as well as the overall concern for providing a safe and healthy environment for all students.

Schools should be employing more, not fewer, school nurses to address the health care needs of students with serious health impairments. Court decisions have mandated that schools provide these services but often do not designate who is to perform them. Ironically, school nurses are often among the first to go when layoffs occur, and many of these nurses have overseen several facilities. So in many schools, the immediacy of the need for health care services means that teachers, paraprofessionals, and other school personnel often are being required to perform health care procedures in addition to their normal educational responsibilities. And these procedures often are performed with minimal training and supervision, without proper facilities for cleanliness and sanitation, and generally under conditions that raise serious concerns about quality of care.

What's Legal? Who's Liable?

Besides the obvious concern for providing a safe and healthy environment for all students, there are other concerns that pertain to school nurses, public health nurses working in the schools, and other school employees. All nursing procedures ultimately are the legal responsibility of the health professional/school nurse assigned to a facility. State laws, called Nurse Practice Acts, usually require that nursing procedures be performed only by a person educated and licensed to practice as a registered nurse, unless he or she has trained another person and is confident of that person's ability. In this case, the nurse may delegate a task to an individual, but the nurse retains full responsibility and liability should any problem arise. Not all procedures can be delegated, however, and each state's board of nursing makes these determinations. Unfortunately, many school personnel are not aware of these facts.

Teachers and paraprofessionals often are designated to perform nursing procedures by their school principal or another supervisor. This is clearly in violation of most state nurse practice acts. Generally, only the nurse assigned to a particular school can delegate nursing duties, and the person to whom the task has been delegated must be properly trained, and under the supervision of a licensed nurse. If a mistake is made and a child injured, under most state nurse practice acts, it is the nurse who is legally liable.

AFT Position on Medically Fragile Children in Schools

The AFT believes that medically fragile children in conventional school settings-should be placed in a safe and healthy environment where their health needs are attended to by professionals and trained support personnel. We recommend that the nurse and health care aide, respectively, have the primary responsibility for providing health care services to medically fragile children. Teachers, paraprofessionals, and other school personnel should not be the primary service providers. School districts and state legislatures must ensure that there are adequate numbers of nurses and support personnel to provide health-related services to children who need them.

Procedures must be established by state law to ensure that a medically fragile child should only be placed in an educational setting when orderly, professionally responsible decisions can be made. These decisions should be made in accordance with the child's needs; when the proper facilities, equipment, and services are available; and when the provision of care will not unduly disrupt the educational progress of the other students.

The role of the school nurse must be standardized, in accordance with the state's Nurse Practice Act, to clearly articulate the nurse's involvement in the preparation of the Individualized Education Program (IEP) and responsibilities for delegation of nursing duties to properly trained personnel, such as those delineated in the Joint Task Force Report for the Management of Children with Special Health Needs, of which AFT is a member.

The AFT strongly recommends that school personnel working with medically fragile children be informed when these children have communicable diseases, the potential risks of exposure to the disease, and the proper precautions to take.

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Chapter 2

The School Nurse

Thanks to today's advanced medical technology, children are surviving what once would have been fatal illnesses and congenital anomalies. P.L. 94-142 and IDEA provide for public education of these children "in the least restrictive environment." Now schools educate and care for children with health needs that are extensive in nature and which require sophisticated intervention. These increasing health care demands, coupled with shortages of school nurses, require formal partnerships among all levels of school personnel to provide for the care and well-being of these medically fragile students. The formation of these health care teams of primarily non-medical personnel creates additional levels of responsibility for the school nurse.

Roles and Responsibilities to Students

The role of the school nurse in the care of students is to assess the health needs of the child in the school setting and to coordinate with staff, family, physician, and community agencies to provide a comprehensive school health program that facilitates the maximum educational opportunity for the individual. This responsibility has escalated dramatically during the past decade with the inclusion of more and more medically fragile children in neighborhood schools.

Each state establishes its own health screening criteria for students, which range from minimal to comprehensive. But no matter what the requirements, the school nurse follows certain standards of practice in fulfilling his or her responsibility to the student. Standards of practice for the school nurse have been developed by a task force of organizations, including the National Association of School Nurses (NASN). These standards serve to ensure high-quality, comprehensive care for school children, as well as to guide the school nurse in daily activities and planning. These standards include the following:

1. Application of appropriate theory as the basis for decision making in nursing practice.
2. Establishment and maintenance of a comprehensive school health program.
3. Development of individualized health care plans.
4. Collaboration with other members of the school health team in assessing, planning, implementing, and evaluating programs and school health activities.
5. Promotion of optimal levels of wellness in students, their families, and others through health education.
6. Participation in continuing education, peer review, and other activities to maintain profes-

sional development and excellence.

7. Participation with others in the community to provide a continuum of the process to promote healthy lifestyles and to prevent disease.

Roles and Responsibilities to Non-Nursing School Personnel

The role of the school nurse in working with non-nursing school personnel is to determine the orientation, education, and training necessary to enable them to participate in a safe and appropriate manner in meeting the health needs of the medically fragile child.

As mentioned before, non-nursing school personnel, by and large, have no training in health-related fields. Moreover, most had never anticipated having to perform health care procedures when they prepared to become teachers or school employees. Many have struggled with their anxieties over this additional responsibility as they work to provide high standards of education for their students. Because these school staff are with the students the majority of the day and are the primary caretakers, it is imperative that all members of the team—teachers, paraprofessionals, other classified personnel, related service providers, etc.—are trained to participate in appropriate procedures/activities and know when to call or contact the school nurse or secure emergency assistance.

The school nurse will help team members understand their capabilities as well as their limitations in participating in the health care process. All team members should have a basic understanding of the legal issues surrounding the provision of care, including knowledge of state nurse practice acts regarding delegation. Beyond that, the school nurse will also assess student needs, determine how the staff can participate in meeting those needs, then develop a training program and resource material to satisfy those goals and finally supervise delivery of the care.

In order to ensure that this is accomplished, the school nurse should:

- Develop a procedure or policy manual in cooperation with other appropriate personnel and update it on a regular basis.
- Establish a uniform recording system, with standardized forms, for use by all staff. These should include, for example, a nursing intake sheet and medical alert sheets.
- Train staff on (appropriate) procedures and routinely assess individual's ability to perform those procedures safely.
- Keep a documented list of trained staff, when they were trained, periodic re-evaluations, and the school nurse's assessment of their capabilities.
- Develop emergency procedures/evacuation plans, and train and evaluate staff in these areas.
- Arrange for or provide in-service training on basic first aid and CPR training.
- Arrange for or provide in-service training on child-specific administration of medication—when appropriate.
- Arrange for or provide in-service programs on current health issues.
- Arrange for or provide in-service programs on universal precautions and the appropriate disposal of contaminated waste.

Legal Considerations for the School Nurse

As the nurse well knows, the Nurse Practice Act in each state governs the scope of nursing practice and limits those nursing tasks that may be delegated to an unlicensed person. When the school nurse has responsibility for several different facilities or is not present at the school site, he/she still maintains responsibility and liability for care delivered. Ensuring that care is appropriately delegated—within the requirements of both the Nurse Practice Act and school administration policy—is crucial.

It is extremely important that nurses are aware of the extent of their liability in these situations.

Unfortunately, that's often difficult because of the vague language of many state laws describing what can be delegated and to whom. Experts recommend that the nurse become as familiar as possible with administration policies that may exist regarding this, but most important know the law. The following four points can serve as guidelines in helping the nurse determine appropriate delegation.

SAFETY: Student safety must be the primary concern at all times. If there is concern that the complexity of the task endangers student safety if not handled by an individual with advanced skills, don't delegate.

STAFFING: Don't let short staffing predicate who gets a particular assignment or "fills in" in a pinch. Know the skill level and capabilities of all team members to determine who can best do the job. If no one else is capable, don't delegate.

SCHOOLING: Consider all the educational components in a person's background, including in-service and experience, before asking that person to participate in specific procedures. Make certain you've observed and, if necessary, corrected technique; if not, don't delegate.

SUPERVISION: The keys to safe delegation are adequate supervision and being available should questions or problems arise. If you can't be sure of either, don't delegate.

If the school nurse is pressured to delegate inappropriately, or becomes aware that a principal or another administrator is attempting to delegate nursing duties, the nurse should immediately inform the administrator of the specifics of the state's Nurse Practice Act and the liabilities involved in violating it. A letter designed to be used by school personnel who are asked to perform nursing duties and which could also be adapted for use by school nurses, is included in Appendix G. The school nurse must also notify the state Board of Nursing in writing about the inappropriate delegation.

In addition to state law and school policy, there is another resource designed to help the school nurse and all other school personnel determine which individuals can appropriately perform various tasks. A task force, including the AFT, put together a booklet called "Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting." Included in this booklet is a matrix that outlines 66 special health care procedures that some children will require during the school day and then delineates the appropriate individual(s) to carry out the procedure. Although not a legally binding document, the booklet has gained a great deal of recognition for its utility, and many school districts have adopted it as policy. The booklet is included in this manual in Appendix D.

Resources

School nurses have myriad responsibilities and often work in situations that afford little opportunity for collegial support and advice. By and large, there are not enough in-service opportunities for the working nurse, or paid time off with provisions for coverage while the nurse is at a seminar or conference. Staying on top of what is current is more difficult, too, when working outside of acute-care facilities. Therefore, the school nurse needs to establish a network of resources that can respond to professional needs and through which she/he can remain current on legal and practice issues.

THE AMERICAN FEDERATION OF TEACHERS

Your union is your best resource whether at the local, state, or national level. And, it is important to become familiar with the structure and staff of your union. Not only can union staff help you with contractual problems or questions, but they can also help find answers or resources to other questions. Make certain you keep your local union informed of problems in your workplace as well as issues that the union needs to address in negotiations.

THE NATIONAL ASSOCIATION OF SCHOOL NURSES (NASN)

The NASN is a willing and excellent resource for the school nurse. Over the years, the NASN has worked cooperatively with both the AFT and its health care division—the Federation of Nurses and Health Professionals (FNHP). As the specialty practice group for school nurses, NASN has expertise in identifying and solving many of the problems that confront school nurses daily.

National Association of School Nurses
Address: P.O. Box 1300
Scarborough, ME 04074
Phone: (207) 883-2117

STATE BOARD OF NURSING

Your state board of nursing is another valuable resource that can help you with some of the more specific or difficult practice questions. The board can provide you with information about your state's Nurse Practice Act. It should also be able to refer you to experts in your field who can answer questions you may have or perhaps conduct workshops for groups of school personnel. Addresses of each state's board of nursing are listed in Appendix F.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING

In addition to your state board, the National Council of State Boards of Nursing Inc. can help you with policy and practice issues.

National Council of State Boards of Nursing
Address: 676 N. Clair St.
Chicago, IL 60611
Phone: (312) 787-6555

Chapter 3

Legal Questions about Medically Fragile Children

by Elizabeth A. Truly, Esq.
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The laws covering the education of medically fragile children are complicated. Although federal laws about the education of students with disabilities pertain to all students with disabilities including medically fragile students, laws, regulations, and court decisions at the state level vary. This chapter will explain the issues surrounding the care of medically fragile students in schools as they are covered in federal law, regulations, and court decisions. State laws expand and interpret the federal laws in many different ways too numerous to cover here. Your state nursing board, state school nurses association, and state department of education, however, can provide information and assistance in helping you deal with situations as they arise in your school district. This chapter provides an overview of federal laws and regulations, and is not a complete discussion and description of the law. For more complete coverage, you should refer to the documents that are referenced in "Readings and Resources", under the section on Legal Resources.

In Chapter 1, we summarized the laws that cover students with disabilities generally—the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Vocational Rehabilitation Act—and broadly discussed how medically fragile students are covered under those laws. This chapter more fully addresses the federal laws, and other legal and regulatory structures governing the health-related services that must be provided to medically fragile students so that these children may fully benefit from their education.

The chapter is divided into five major sections:

- IDEA and Section 504 as they pertain to students with significant health impairments;
- the role of state nurse practice acts in determining and regulating how services should be provided to students with significant health impairments;
- the importance of keeping complete and confidential school health records for such students;
- liability issues for school personnel including school nurses; and
- Do Not Resuscitate orders.

The IDEA and Medically Fragile Children

Passage of P.L. 94-142, the Education for All Handicapped Children Act, in 1975, was prompted by a congressional finding that one-half of the 8 million disabled children in the United States did not receive appropriate educational services and that one million children had been excluded entirely from the public school system. Accordingly, Congress was quite clear that "state and local educational agencies have a responsibility to provide education for all handicapped children." Consistent with this mandate, the concept of "education" under IDEA is broad. Under the IDEA's "zero-reject" policy, even students with profound health impairments are entitled to services. For these children, related services (physical therapy, occupational therapy, health/nursing services, speech therapy) form the core of the child's special education. The law is very clear that schools must provide the services these students need in order to benefit from their education.

Notwithstanding this broad mandate, however, there are important limitations on the extent of a school district's obligation to medically fragile children and issues that must be considered in deciding where an IDEA-eligible medically fragile child should be served.

Health Service as a Related Service: the Medical Service Exclusion

We have spoken about how related services make it possible for disabled students to benefit from their education. The term "related services" is defined in the IDEA as those supportive services required to assist a child with a disability to benefit from special education. One example of related services specifically included in the regulations is "medical services." However, the law restrictively defines "medical services" as services that are for diagnostic and evaluation purposes only. The federal regulations interpreting IDEA say that "medical services" are services provided by a licensed physician to determine a child's medically-related disability. Included in the regulations, but not in the law as "related services," are "school health services." The regulations define "school health services" as services provided by a qualified school nurse or other qualified person, as a related service. What are the distinctions, and what does this all mean?

Schools are required to provide "school health services" but they are not required to provide "medical services" other than diagnosis and evaluation. This limitation on school districts' responsibility for "medical services" has come to be known as the "medical exclusion." It is hard to draw the line between required "school health services" and excluded "medical services," and the courts have been called to address the issue on more than one occasion. Since the expertise of school personnel, particularly school nurses, and the nursing profession have rarely been presented in this litigation, there has been much confusion leading to yet more litigation.

The first major case to address this issue involved a student named Amber Tatro, who born with spina bifida, was unable to control her bladder function. She required clean intermittent catheterization (CIC) in order to attend school. The school district argued that CIC was an excluded "medical service." Relying on the regulations stating that medical services were "services provided by a licensed physician," and evidence presented by the student's family that CIC could be performed by a nurse or a minimally trained layperson, the court concluded that CIC was a required "related service" for Miss Tatro.

However, the court's ruling did not consider the scope of nursing practice under the Texas Nurse Practice Act. School districts and their attorneys sometimes mistakenly interpret this case as authorizing unlicensed, i.e., non-nursing personnel, to perform CIC in any classroom in the country. In addition, advocates often mistakenly interpret this decision to mean that if parents can provide these services for their children in the home, then teachers or paraprofessionals can provide these services in the classroom. This thinking also fails to take into account state nurse practice acts and the realities and central mission of the classroom.

The courts are currently divided about how much responsibility school districts bear for children who require constant and extensive nursing services in order to benefit from their education. One recent case holds that if the service can be delivered by someone with less training than a physician, a school district must provide it. Other cases, however, have focused on the nature and intensity of services required by particular students and the level of skill required by the person performing the service. Under this line of cases, if the care required is intermittent and can be provided by a regular school nurse, the service is an eligible related service, but if the care required is more like private duty nursing, the service is an excluded medical service. Because of conflicting interpretations by the courts, school district obligations vary from state to state.

In many, if not most, of the cases involving children with complex medical needs, the primary issue is who pays for the service. Parents are not required to use private insurance to pay for related services required by the IDEA. Some State Medicaid agencies would rather shift the burden to the local school district. School districts, often struggling to keep up with the rising costs of providing ever-more complex health-related services to increasing numbers of students with intense medical needs, want that line to be more rigidly drawn in favor of outside agency responsibility.

Complicated Staffing Issues.

When it is determined that the school district does not have to pay, the parents' insurance company or Medicaid provider may be responsible. Under these circumstances, a non-district employed registered or licensed practical nurse may accompany the child to school, which raises additional concerns for the school nurse. For example, in most jurisdictions, licensed practical nurses are dependent practitioners, meaning that they work under the direction of a registered nurse, physician, or other health care provider. When a private LPN is in the same building as a district employed registered nurse, the registered nurse may be professionally responsible for ensuring that the care delivered by the private LPN meets established standards. A procedure should be established for the school nurse to follow in instances where the school nurse determines that the private nurse is performing his/her duties in an unsafe manner. It would also be a good idea for the school nurse to seek guidance from the state board of nursing and, if necessary, obtain written clarification of his/her responsibilities from the employing school district.

In addition, the school nurse should not be placed in the position of substituting for a private nurse when that person is unable to perform his/her duties. It is the parent or agency's responsibility to locate a substitute if the primary provider is unavailable.

Least Restrictive Environment Considerations

"Least restrictive environment" is defined as "to the maximum extent appropriate, children with disabilities...are educated with children who are not disabled; and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." How do the factors and the legal requirements of the IDEA's Least Restrictive Environment (LRE) clause play out in situations involving students with complex medical needs? And what contributions can teachers and school nurses make to resolve least restrictive environment issues for this population?

Each child is an individual and presents unique needs. Therefore, it is difficult to generalize regarding the types of issues that can arise in implementing least restrictive environment requirements for children with complex medical needs. Published decisions in court cases and disputes that have reached state review officers give some indication of the problems in the field. So do questions and anecdotes provided by AFT affiliates and members.

We know, for example, that parents have sought educational services for children whose condition is so precarious that "do not resuscitate" (DNR) orders have been obtained, and also for children who can only be safely transported to school in an ambulance. We know that some doctors recommend school-based services for children with serious medical problems in deference to or out of compassion for the child's family. Often, these doctors do not fully understand the nature of school programs or the range of available alternatives. Doctors also may not take into account the demands the program would place on the fragile student or how the provision of services to the student would affect the education of other students, disabled and non-disabled. We know also that some parents believe that their child's health needs should be met in the classroom, which they perceive to be the most "natural" setting, by classroom staff rather than nurses or other health care professionals. We know from our members that districts are often all too willing to accommodate parents' wishes on these issues, largely for fiscal reasons and to avoid due process hearings. Further, school districts and even the courts are sometimes oblivious to the legal implications of these practices under state nurse practice acts.

None of these situations can be resolved satisfactorily without the input of classroom teachers, paraprofessionals, and school nurses.

School districts often believe that they must first try to provide services in the regular classroom, even if they do not believe that providing such services in the regular classroom is appropriate. These districts think that only if they have failed in this attempt will they have satisfied least restrictive environment requirements. Rather, the law requires districts to consider whether a student with a disability can be educated satisfactorily in a regular class with appropriate aids and services. If the answer is no, the regular class is not the least restrictive environment for that child.

That said, however, classroom teachers and paraprofessionals are in a better position to assess the impact of providing a particular health service in the classroom if they allow a parent or a properly credentialed professional to perform the service on a trial basis during classroom instruction. With actual experience, the teacher or paraprofessional objectively can describe the impact that service delivery has on the classroom—the ability of the teacher and paraprofessional to maintain concentration; ability of other children in the classroom, who may themselves be disabled, to stay on task. Similarly, if the service is provided to the child in the health room or nurse's office, the teacher and paraprofessional are in a better position to judge whether the removal affects the child's ability to benefit from the instructional program. We hear too often how either the services do not get properly provided because the classroom cannot support the service, or that so many people are in the classroom providing services that the classroom becomes chaotic. In such situations, teachers and paraprofessionals cannot provide a viable instructional program for any of the students.

The Role of the School Nurse in Resolving LRE and Service Provider Issues

The school nurse's input is essential in determining where services should be provided to individual students. While a doctor may express an opinion or even write an order stating that a service can be delivered in the classroom, under most state nurse practice acts, the nurse is responsible for assessing the situation and determining if it is in fact appropriate to provide necessary services in general classrooms. Backed by authorities such as the Project School Care manual produced by the Children's Hospital of Boston, school nurses have made persuasive cases that certain procedures should not be provided in the classroom.

The school nurse's knowledge of the state nurse practice act can also guide the district in identifying the appropriate service provider. The school nurse may in fact be the only employee who can effectively explain why it is inappropriate to assume that if a parent can perform the procedure at home, a teacher or paraprofessional can or should perform the procedure in school. It is a school nurse's role to perform a health assessment of the child and decide, with guidance from the state board of nursing if necessary, whether the services required by the child can be delegated to non-nursing personnel. If the school nurse believes that it is appropriate to delegate a task to a person who is not a nurse, then the nurse determines what type of training that person requires, whether the person can perform the procedure consistently and competently, and whether, over time, it is still appropriate to delegate the task based on the needs of the child.

Section 504 and the Medically Fragile Child

Section 504 of the Vocational Rehabilitation Act differs from the IDEA in a number of respects: it is an anti-discrimination law rather than an entitlement program; no funds are appropriated for school districts or other covered entities or programs to implement its mandates; it covers employees as well as students; the definition of an "individual with a disability" is broader and less specific than the definition in the IDEA; it covers students who do not require special education and related services; procedural requirements are less rigid than those contained in the IDEA; and, like other civil rights statutes, it is enforced through a complaint and investigation process. All IDEA-eligible students are also covered by Section 504, but the reverse is not true. The population of Section 504-eligible students is much larger than the population of IDEA-eligible students, and most students who are only eligible to receive services under Section 504 receive services and accommodations in a general education setting.

School districts that operate public elementary and/or secondary education programs have a number of specific responsibilities under Section 504. Notwithstanding the fundamental differences between Section 504 and the IDEA, many of these obligations mirror or bear strong similarity to school district obligations under IDEA. School districts receiving federal funds must: (1) annually identify and locate all unserved disabled children; (2) provide a "free appropriate public education" to each student with disabilities, regardless of the nature or severity of the disability; (3) ensure that each student with disabilities is educated with nondisabled students to the maximum extent appropriate to the needs of the disabled student; (4) establish nondiscriminatory evaluation and placement procedures; (5) establish procedures to enable parents and guardians to participate in decisions regarding the evaluation and placement of their children; (6) afford disabled children an equal opportunity to participate in nonacademic and extracurricular services and activities; and (7) establish impartial hearing and review procedures for parents who want to challenge school district decisions regarding identification, evaluation, and educational placement of their children.

There is no language under Section 504 that specifically requires school districts to develop individualized education programs for students with disabilities who are not IDEA-eligible. However, the Section 504 regulations suggest that compliance with IDEA procedures is one way to meet the requirements of Section 504. There are sound practical and policy reasons for districts to document modifications and accommodations for Section 504-eligible students. Among other things, a written plan can document the child's disability, the basis for determining that the child is entitled to Section 504 services, the specific modifications and accommodations recommended, and the participation of parents and staff in the evaluation and recommendation process. More important, a written plan informs responsible staff members of what they are expected to do. Many districts have developed Section 504 Accommodation or Intervention Plans for students who require instructional modifications and Individualized Health Care Plans for students who require health related services.

A large portion of students eligible for Section 504 services have hidden disabilities—that is, disabilities that cannot easily be perceived. Many of these are medical or health related problems. Students with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (ADD/ADHD); severe allergies; asthma; asthmatic bronchitis; cancer; cystic fibrosis; diabetes; heart disease; kidney, liver, or urinary tract ailments; encopresis; epilepsy; high blood pressure; juvenile rheumatoid arthritis; HIV/AIDS; Tourette's syndrome; hearing or visual impairments; Hepatitis B; ulcers or orthopedic impairments who are not IDEA-eligible may still be covered by Section 504, provided that their impairments substantially limit a major life activity.

State Nurse Practice Acts

The Regulatory Framework for the Practice of Nursing

Registered nurses are licensed professionals. Most states license practical nurses as well, and some states license nursing assistants. State nurse practice acts are laws that define the practice of nursing for these licensees. They set forth the requirements for obtaining a license to practice nursing, describe the scope of nursing practice, and establish the framework for oversight of the nursing profession and those who practice nursing. Nurse practice acts typically include language that prohibits unlicensed persons, excluding family members and individuals responding to an emergency, from practicing nursing. In most states, practicing nursing without a license is a criminal offense punishable by a fine and/or a jail term. The crucial issue of delegation, discussed at length in this chapter, is often addressed in state nurse practice acts.

Nurses, like most teachers, are accountable to both their school district employers and to their state licensing authority. For teachers and most other school employees the dual accountability structure does not pose a conflict because both the district and the state licensing authority have responsibilities that are associated with providing educational services. For school nurses, however, the lines of accountability often pull in opposite directions. Schools are responsible for providing educational services; state nurse licensing authorities are responsible for protecting the people of the state by ensuring that those who provide health care are qualified to do so. School boards and administrators usually do not understand the roles and responsibilities of the nursing profession. In addition, many schools reluctantly have accepted responsibility for providing health care beyond minimal public health services and first aid. Nurses, many of whom are without union protection, face difficult challenges in trying to carry out their obligations as nursing professionals in school administrations that may be ignorant of or even openly hostile to school nurses' professional responsibilities.

Scope of Practice: The Definition of the Practice of Nursing

Licensure authorizes licensed persons, in this case nurses, to perform the functions specified in the profession's licensure act. Unlicensed persons, i.e., school administrators, can assign other unlicensed persons to perform tasks and activities that are outside the scope of nursing practice. But only nurses can delegate activities within the scope of nursing practice to other licensed and unlicensed personnel. It is important to understand what the "scope of nursing practice" means in order to determine whether a school district is providing health services consistent with state law.

Nurse practice acts differ from state to state. For example, Oregon law defines the practice of nursing as:

> diagnosing and treating human responses to actual or potential health problems through such services as identification thereof, health teaching, health counseling, and providing care supportive to or restorative of life and well-being and including the performance of such additional services requiring education and training which are recognized by the nursing profession as proper to be performed by nurses licensed under [Oregon Law] and which are recognized by rules of the Board.

The practical application of this language to school settings is elusive to most unlicensed persons (including lawyers). The Oregon law and many other state statutes are extremely difficult to translate. In many cases these laws appear to offer little assistance in figuring out who can and cannot perform a particular health-related activity in a school setting. How then do school personnel—administrators, teachers, paraprofessionals, and nurses—get clear directions about their proper roles and responsibilities?

The answer usually lies with the state's board of nursing, either alone or in collaboration with the state's department of education. It is the role of the state's board of nursing to determine who should be providing care for medically fragile children in the school setting. It is also the role of the state, both the board of nursing and the department of education, to ensure that services are provided in a way that safeguards the health and safety of students. Some state boards of nursing and state departments of education, such as New York's, have issued joint memoranda explaining the roles and responsibilities of school administrators, school nurses, and other school personnel in providing nursing and health related services for students in the school setting. The New York memorandum (see Appendix D) contains lists that specifically identify activities which must be performed by registered nurses; activities that can, with training and the approval of a registered nurse, sometimes be performed by unlicensed personnel; and activities that can usually be performed by unlicensed personnel. In other states, state departments of education in collaboration with state boards of nursing have issued handbooks or guidelines to assist school personnel. Connecticut, Montana, and Utah have all taken this approach. In Oregon, the State Board of Nursing issued declaratory rulings in response to complaints or inquiries from school personnel. It is likely that other states are also following this path.

Although state boards of nursing and state education departments have become more responsive to the concerns of school personnel, we do not want to leave the impression that clear definitions of the roles of licensed and unlicensed personnel in schools are always available. The scope of practice of nursing is purposefully described in law in a manner that is broad and subject to differing interpretations in varied contexts. The setting in which the care is provided, the availability of technology, and the characteristics of the student who requires services are all important in determining whether a particular activity requires nursing skill or judgment. Because so many decisions about a particular situation must be left to the judgment of the nurse, this is an area in which certainty is elusive and problems are likely to persist for many years to come.

Delegation of Nursing Tasks in the School Setting

The National Council of State Boards of Nursing defines *Delegation* as transferring authority to a competent individual to perform a selected nursing task in a selected situation. Some state statutes deal explicitly with the issue of delegation of activities to other licensed persons (such as licensed practical nurses and nursing assistants) and to unlicensed (i.e., non-nursing) persons. Other states address the issue of delegation in regulations, through administrative or declaratory rulings from the state's board of nursing, or by opinion letters from the state attorney general. The issue of delegation, which is of crucial importance for nurses providing services in school settings, is often addressed directly or indirectly in the state nurse practice acts.

A few states allow registered nurses to delegate nursing tasks only to other licensed personnel such as practical nurses or nursing assistants. Most states permit registered nurses to delegate nursing tasks to unlicensed assistive personnel. Nurses who delegate nursing tasks are required to supervise the performance of delegated tasks. The nurse must provide guidance for performing the procedure, and periodically observe the person as the procedures is being performed to be certain it is being performed properly.

The following principles generally apply to the process of delegation:

- The decision to delegate a procedure for a specific child can only be made by a nurse who is qualified to perform the procedure.
- Performance of nursing procedures that have not been properly delegated by a qualified nurse and/or are not being supervised by a qualified nurse constitutes the practice of nursing without a license.
- The licensed nurse must ultimately make decisions about delegation of nursing procedures. Employers and administrators may only suggest which nursing acts may be delegated and to whom the delegation may be made.
- Decisions about whether delegation is appropriate are based on:
    - the stability of the client's condition;
    - the nature of the task;
    - the predictability of the outcome and the need for professional judgment during the performance of the task;

  - the competency of the available staff;
  - the appropriateness of using particular staff members in light of their other responsibilities; and
  - the availability of the nurse to supervise implementation of the procedure.
- Although parents can collaborate with school personnel in developing a plan of care and preparing other school personnel to serve their child's health needs, the school nurse is responsible for deciding whether delegation is appropriate. The nurse must arrange for or provide training, assess the competence of the delegate, and also supervise the provision of care. The nurse also must document the training and periodic re-evaluation.
- Delegation decisions must comply with the delegation requirements and guidelines of the state.
- Although certain nursing tasks and procedures may be delegated, the functions of assessment, evaluation, and nursing judgment can not be delegated.
- An unlicensed person delegated to perform a nursing task may not transfer that task to another person.
- The delegating nurse is responsible for delegated care whether the nurse is physically present or not.

Ideally, school districts should have policies and procedures regarding the delegation of nursing services. These policies and procedures should be based on the state's nurse practice act. If guidance is needed, it should be obtained from the state board of nursing. In addition, school nurses, administrators, teachers, and paraprofessionals should be involved in developing the policies and procedures pertaining to delegation. These individuals are in the best position to provide information about how delegation will work in their particular school setting.

The following hypothetical drawn from an actual case presented to the Oregon State Board of Nursing illustrates practice that violates state regulations on delegation of nursing tasks and explains how the principles of delegation should operate in a typical school situation.

The parents of a child with spina bifida informed the school administration that their child needed clean intermittent catheterization in order to attend school. The principal directed a health assistant employed by the district to perform the procedure. The parent taught the health assistant how to perform the procedure in the presence of other school personnel, including a contract agency school nurse. The school nurse was subsequently requested by the district to observe and supervise the health assistant and did so. The child did not suffer any adverse consequences as a result of the care provided by the health assistant.

In response to the health assistant's claim that she had been directed to perform a nursing procedure in violation of Oregon's State Nurse Practice Act, the Oregon Board of Nursing issued a ruling declaring that (1) the principal and other school authorities were engaged in the practice of nursing when they assessed the health status of the student, directed a health assistant to perform the task, and decided how the teaching of the task was to be accomplished; (2) the health assistant was engaged in the practice of nursing in implementing the directive; (3) the school nurse's passive role in accepting the assessment by school authorities was below the expected standards of nursing practice.

According to the Oregon State Board of Nursing, when the student entered the school system with a health problem, it was the responsibility of the school nurse to perform an assessment and to develop and implement a plan for meeting the student's health needs. If the nurse determined that it was safe to delegate the procedure required by the student to an unlicensed person, the nurse should have arranged for the teaching of the task to the health assistant. Thereafter, the nurse should have provided regular guidance to and oversight of the health assistant.

While the National Council of State Boards of

Nursing recognizes health aides and classroom paraprofessionals as persons who may properly function as assistive personnel to provide health-related services, instructional paraprofessionals (much like teachers) are usually poor choices as delegates because their responsibilities to other students allow them little time to attend to the specific health needs of a medically fragile child. In addition, paraprofessionals may be limited by their contract to perform only instructional duties.

School Health Records

Overview

Documentation raises many difficult and complex issues for school nurses. According to the National Standards of School Nursing Practice, school nurses must document each student encounter and each aspect of the nursing process. The Standards call for these practices in order to promote:

- consistent and continual care,
- regular evaluation of students' Individualized Health Plans, and
- subsequent revisions in care.

But schools are not health care institutions, and school administrators may not understand the purposes or requirements of nursing documentation. State laws may treat certain relationships as confidential or prohibit disclosure of certain types of information. Yet the federal law requires school districts to provide parents the opportunity to review and inspect educational records, and does not make distinctions between records maintained by school health professionals and other types of school records. In school districts where accountability for school health issues does not rest in a licensed health care professional, school nurses bear enormous responsibility for educating school administrators about meeting documentation requirements, establishing appropriate school recordkeeping systems, and maneuvering through conflicting legal requirements.

Documentation Standards: If It Wasn't Written It Wasn't Done

Documentation is the best protection against liability for school nurses and assistive personnel. Parents can be expected to sue school districts and school personnel when they believe that their child has suffered adverse consequences because of neglect or substandard care by school health personnel. Nevertheless, school nurses and assistive personnel can take steps to protect themselves if they are sued. They can do this by clearly and completely documenting student encounters and each step of the nursing process or delegated activity, using an individual, student-specific record. This documentation should be ongoing, not quickly put together later, when it might appear to be fabricated or a cover-up. When the school nurse delegates a nursing activity, documentation of the nursing process should include a record of case-specific training and oversight provided to assistive personnel.

The Family Educational Rights and Privacy Act (FERPA) and School Nurses

Legal Obligations Imposed by FERPA

The Family Educational Rights and Privacy Act, commonly known as FERPA or the "Buckley Amendment," requires every school district to annually notify parents and eligible students (over 18 years of age) of their right to inspect and review the education records of the student. FERPA defines educational records as records that are directly related to a particular student and maintained by an educational agency or institution. The term "record" means any information recorded in any way including, but not limited to, handwriting, print, tape, film, microfilm, and microfiche.

FERPA also:

- requires school districts to respond to reasonable requests for explanations and interpretations of records;
- allows school districts to disclose personally identifiable information to other school officials, including teachers, whom the district has determined to have legitimate educational

interests, and to other schools, school systems, and post-secondary institutions in which the student seeks or intends to enroll;

- permits information to be revealed to appropriate parties in an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals;
- establishes strict requirements for obtaining written parental consent for access to and disclosure of information from educational records with a number of carefully defined exceptions; and
- gives parents the right to request amendments to educational records that are believed to be inaccurate, misleading, or violative of the student's privacy right.

There are special exceptions, called "sole possession" exceptions, to FERPA rules for personal notes of nurses and other professionals. However, rulings interpreting this section of the Act make it clear that if the record is created or maintained in response to school district policy or procedure; is discussed with other school personnel at staffing, support, or IEP team meetings; or is the basis for a service recommendation, it may not be shielded by the "sole possession" exception. Therefore, if school district policy requires that school nurses document student contacts and maintain nursing process notes, these documents are subject to disclosure under FERPA.

Issues for School Health Providers

School nurses are required by the standards of their profession to document information relating to students' health status—including information about highly sensitive issues such as pregnancy, drug and alcohol abuse, suspected child abuse, etc.—but federal law requires school districts to allow parents access to this information. Hospitals and physicians may provide schools with voluminous treatment records believing that the schools will keep the records confidential. In fact, schools are not able to honor that expectation. State laws may protect the confidentiality of communications between students and various professionals or provide that various kinds of information be treated as confidential, yet federal law may override these protections. Nurses who fail to document sensitive information out of concern for the student's safety or privacy may, at the same time, place the student at risk and expose themselves to liability.

Recommendations for School Nurses and Other Health Providers

Many states and local school districts have developed school health record policies and procedures that are sensitive to the legal and professional dilemmas faced by school health personnel. The Readings and Resources section of this publication lists some of the best state guidelines we have found. However, if you are in a state that has not developed guidelines, you should work with your union to initiate a process that will get you the information you need. Since laws vary, the guidelines in your state and school district will have to address issues that arise under the laws of your state.

The following recommendations, drawn from Schwab and Gelfman (1991) and Schwab (1996), will help you get started:

- Learn about the documentation policies and issues in your state by contacting your state's education department, board of nursing, and the state affiliate of the National Association of School Nurses.
- Obtain copies of school district policies and procedures regarding student records and talk with school psychologists, social workers, guidance counselors, teachers, and other school professionals about how they handle confidential information.
- Inform school administrators about the documentation standards for the nursing profession and the need for clear district policies and procedures for nursing and health care documentation. If your district does not have clear policies and procedures, work with administrators to develop them.
- Obtain legal advice from your state education department and/or request rulings from your state board of nursing on how to handle con-

flicts between state and federal laws regarding confidentiality and disclosure of school health records.

- Examine the kinds of school health records your district maintains, classify them according to the degree of confidentiality required, and make recommendations regarding appropriate recordkeeping systems. Access to student health information should generally be limited to school personnel who need to have the information in order to provide a safe learning environment for the child or to respond appropriately in case of emergency. School nursing process notes and hospital and physician records should be accorded the maximum protection.
- Record objective information rather than conclusions and whenever possible provide an assessment of the student's health care needs rather than a medical diagnosis. This is particularly important if the record could be used in legal proceedings (family court or children's protective services) or is developed for use by non-medical personnel (classroom teacher, paraprofessional, multidisciplinary team, etc.).
- Avoid use of a daily log as the sole record of student visits to the health office. Using a cumulative log limits the ability to track individual student health needs, does not provide accessible information for substitute nurses, and presents difficult issues under FERPA because it contains personally identifiable information about multiple students.

For more information on keeping and protecting student records, see "Protecting the Privacy of Student Education Records," distributed by the National Center on Educational Statistics.

Liability

The circumstances in which many nurses practice carry great potential for litigation. School nurses do not have the facilities, equipment, or clinical support typically available in other health care settings. School nurses usually work independently and are responsible for students with diverse health and medical needs. Since the passage of the IDEA, school nurses have been called upon to care for children who would not have been expected to attend school 20 years ago. Some courts have even interpreted the IDEA as requiring schools to provide the equivalent of private duty nursing for students with complex, life-threatening conditions. Many school nurses bear the added responsibility of providing care for students who do not have regular contact with a family physician and who live in conditions where communicable diseases, teen pregnancy, drug and alcohol abuse, poverty, and violence are prevalent.

But the good news is that in spite of all of the potential for litigation, school nurses are not sued very often. When school nurses are sued, usually they are named as additional defendants in lawsuits against school districts. When this is the case, school nurses may benefit from state laws and court decisions that narrowly define the duty of school districts and school district employees, require persons who wish to sue to prove something more than simple negligence, or provide immunity for actions undertaken in the course of school district employment. In addition, most states require school districts to defend the school nurse, or reimburse legal fees, when the nurse is sued for actions taken in performing the duties of the job.

The purpose of this section is to give a basic overview of negligence litigation, to briefly touch on other types of lawsuits filed against school personnel, and to provide some recommendations to help school nurses avoid liability.

Negligence

The concept of negligence is straightforward. The traditional elements necessary to establish a claim are as follows:

1. a legally recognized *duty* to conform to a certain standard of conduct for the protection of others against unreasonable risks;
2. a *breach of duty*, i.e., a failure on the part of an individual to conform to the standard;
3. a reasonably *close causal connection* between the conduct and the resulting injury (often referred to as "proximate cause");

4. actual *loss or damage* to the interests of another.

All four elements—duty, breach of duty, close causal connection, and loss or damage—must be present for liability to be established.

The minimum standard of care to which an ordinary citizen is held is that of a "reasonable person.," i.e. someone who embodies what the community expects of a prudent, cautious person. But where the person has knowledge, skill, or intelligence greater than the ordinary person, the law expects the person's actions to be consistent with those additional qualifications. Professionals are required to have a minimum of special knowledge and ability. They are held to the standard of what is customary and usual in their profession.

School nurses have a duty to meet the standard of care in the nursing profession. The standard of care in the nursing profession may be drawn from a number of sources on the national, state, and local levels. On the national level, standards for school nursing practice have been developed by the National Association of School Nurses and the American Nurses Association. On the state level, the duty owed by a school nurse may be established by court decision. If state courts have not ruled on the issue, the state nurse practice act and interpretive rulings and guidelines issued by the state's board of nursing are influential. State education department protocols or guidelines for school nurses may also be referenced in establishing a standard of care. On the local level, people who want to bring a suit could look to the job description of the school nurse and to the policies, procedures, and guidelines adopted by the school board or issued by the administration regarding duties and expectations of school nurses. Other resources about standards of care include nursing textbooks, courses of study, and articles in professional publications.

A school nurse can breach the duty of care by carrying out a nursing act that is below the standard of care or by failing to act in circumstances where a licensed professional would be expected to act. Courts rule that there is causation if a reasonable connection can be made between the act or failure to act by the defendant and the damage or harm which the person bringing the case has suffered.

When someone sues school districts or school employees for acts committed while they are doing their job, in many states that person faces additional hurdles not present in traditional negligence litigation. Some states require plaintiffs to prove "gross negligence" or "willful and wanton conduct." Other states have limited the government's liability for certain types of claims to situations where the government had been notified of the risk of harm. Yet other states impose obstacles such as "notice of claim" requirements. That is, individuals who are considering suing a school district must let the district know of their intentions very soon after the negligence they are claiming occurs. Requirements like these decrease the chances that school districts and their employees will be sued.

In negligence lawsuits, a judge or jury decides whether the person bringing the complaint has proven the claim. If one or more of the defendants is found to be liable, a decision must be made about what portion of the total damages sustained were caused by a particular defendant. In some states, if plaintiffs substantially contribute to their own injury, they are barred from recovery under "contributory negligence." More common today, however, is the standard of comparative negligence which distributes responsibility for damages between parties who are at fault.

Nadine Schwab (1988) identified the following as recurring causes of nursing liability:

- failure to keep abreast of nursing knowledge;
- failure to take an adequate patient history;
- failure to function within established policies;
- failure to function within the scope of nursing education and practice;
- failure to administer medication and treatments properly;
- failure to supervise or monitor patients adequately;
- failure to observe and report changes in a patient's condition;
- failure to document adequately and promptly;
- alteration of records;

- failure to report incompetent care by others;
- improper physician orders; duty to defer execution;
- failure to use aseptic technique;
- use of defective equipment;
- failure to carry out physician's orders;
- abandonment of a patient;
- failure to resuscitate promptly and properly.

Staff can avoid liability by making sure their practices do not fall into any of these categories. In addition, Schwab recommends that school nurses become proactive in confronting the issues that place them at "high risk" of liability:

- professional isolation;
- the need to provide a wide range of nursing services;
- school board policies and procedures that conflict with professional standards for nurses;
- educational laws, such as FERPA, that directly conflict with health laws; and
- lack of clear job descriptions.

Here again we recommend that school nurses seek assistance from their union, state school nurses association, state board of nursing, and state department of education in addressing these issues. The first place to start, however, is with the policies and procedures adopted by your school board and school administration and, more specifically, with your job description. Every school nurse should have a job description and review it regularly.

Liability Under Section 1983

Negligence actions and professional disciplinary proceedings prompt the greatest fear on the part of nursing professionals. But school personnel who serve students with disabilities are being named with increasing frequency in another kind of lawsuit—actions under Section 1983 of the Civil Rights Act of 1871. This Reconstruction era statute, originally enacted to give freed slaves redress against state and local governments and officials who violated their federal rights, is now being used by parents of students with disabilities seeking monetary damages for violation of rights created by the IDEA and Section 504.

Section 1983 is not an independent source of rights. Rather, it allows individuals who believe that their federal rights have been violated to seek money damages and other remedies that may not be available under the federal statute or constitutional provision that is the source of their rights. Federal courts handle a large volume of Section 1983 litigation. These cases arise in many different contexts, and litigation of Section 1983 claims has become quite complex. In cases involving school age children with disabilities protected by the IDEA, courts usually require parents to exhaust IDEA administrative due process—that is IEP meetings, impartial hearings, and state review if required—before filing a court action.

The reaction of the courts to Section 1983 damage claims based on the IDEA and Section 504 has been mixed. Most courts agree that damages are available in Section 1983 cases based on violations of Section 504. And, while courts prefer educational remedies (such as compensatory education and tuition reimbursement) for claims based on violations of IDEA, at least one court has suggested that damages can be awarded against school districts and school personnel in such cases.

Although case law is limited, the possibility certainly exists for individual school district employees to have monetary damages assessed against them if they fail to refer a child suspected of having a disability for evaluation, or knowingly and deliberately refuse to provide a service specified on a child's IEP or Section 504 accommodation plan.

Do Not Resuscitate Orders

A special issue that needs particular attention is the Do Not Resuscitate (DNR) orders that are obtained for medically fragile children who are attending school. DNR orders direct medical personnel not to use extraordinary lifesaving measures-such as CPR, respirators, cardiac shock, etc.-to revive a patient who is dying. Until recently, Do Not Resuscitate orders have generally been placed in effect for terminally ill patients in hospitals and certain other health care facilities. However, many states now permit DNR orders to be issued for less serious conditions, and for patients being cared for outside the hospital setting. School districts are now faced with parents who want their severely medically fragile child to attend school, and who expect the school district to honor physician-issued orders to withhold life-saving treatment. This is a particularly troubling and difficult issue for school districts and school personnel. This section will explain the challenges this issue raises, and how to meet those challenges.

Overview

Do Not Resuscitate (DNR) orders raise a host of considerations for school personnel, for students, and indeed for the entire school community. Teachers and paraprofessionals see their role as one of helping children to learn and to fulfill their potential, not as one of facilitating a child's death. Nurses, although better trained to respond to life and death situations, are not eager to make such difficult and irreversible decisions in a non-hospital setting. The parents of the medically fragile child are anxious and sometimes even desperate to provide their child with a "normal" school experience. Still, these parents want school personnel, students, and other parents to respect the very difficult and painful decisions they have made about responding to their own child's medical emergencies. Some parents of non-disabled children want their children to appreciate the fragility of the human condition, but are hesitant to expose their children to the trauma of death in a setting in which they are not immediately available to provide emotional support and guidance to their child. Other parents simply do not want their children exposed deliberately to such a painful experience. Advocates for the disabled make compelling arguments for and against permitting school districts to honor DNR orders for medically fragile students. Unfortunately, the legal issues surrounding Do Not Resuscitate orders are no less complex than the social and emotional issues surrounding them.

Are school districts legally compelled to require school personnel to comply with requests from parents to withhold life-sustaining emergency care while a child is in school?

OCR's response, while helpful in Section 504 issues, such as the Lewiston case presented here, does not address other legal issues raised by DNR orders. The legal and moral issue at the core of the entire discussion is the so-called "right to die." It is the so-called "right to die" because "right" implies that someone is entitled to something under the law, and in this case, the "right to die" does not exist as a matter of constitutional law. Although the Supreme Court has held that individuals may

The Office for Civil Rights (OCR) evaluated a complaint filed against the Lewiston (Maine) School District under Section 504 and the Americans with Disabilities Act when the school district refused to honor a DNR order. The OCR decided that school districts are not required to comply with such requests. From OCR's point of view, a school district is complying with the law as long as it does not discriminate between disabled and non-disabled students. In the Lewiston case, OCR approved the school district's approach, which provided for the development of individually designed medical resuscitation plans by multidisciplinary school-based teams for students whose individual needs required such plans. As specified in the resolution document, the plan, designed by a multidisciplinary team, described the steps that school personnel should take if the student requires life-sustaining emergency care while under the school's supervision. The team based its decisions about appropriate forms of emergency care on expert medical and other information about the student. The team recorded and documented its decisions in developing the plan, which required that a second medical opinion be obtained to ensure the appropriateness of the lifesaving measures prescribed. The plan's duration was limited, ensuring that it periodically would be reevaluated.

refuse medical treatment, their right to refuse treatment must be balanced against the state's interests in preserving and protecting human life. States may limit the circumstances in which individuals can exercise their "right" to refuse medical treatment.

Even more important, states may restrict or even refuse to honor DNR requests that are made by family members on behalf of dependent children, and states are especially protective of persons who, because of serious mental impairments, cannot participate in or even understand the decisions being made on their behalf. Although states may favor family relationships and allow families to make certain decisions for their children, states are not required to honor such relationships or recognize family decisions in the context of life-saving treatment.

Addressing the Issue

The legal, moral, and ethical questions surrounding this issue are so complex and the potential outcome so final that it would be wise for the local union to obtain independent legal advice concerning the obligations and potential liabilities of its members before weighing in on the issue.

In reviewing the issue, legal counsel should, at a minimum, attempt to address the following questions under state law:

- Does state law permit doctors to issue a DNR order when the patient is not terminally ill or in a persistent vegetative state?
- Does state law limit implementation of DNR orders to hospitals or other specific health care settings?
- If state law permits non-hospital DNR orders, does it limit the categories of personnel who can implement such orders?
- Does state law permit parents to make "substituted judgments" for minors, and, if so, under what circumstances?
- Does state law impose special conditions on parents who seek to make substituted judgments on behalf of children who are not mentally competent, and, if so, what are those conditions?
- What liability protection, if any, does state law provide for school personnel who, in good faith and compliance with school district policy, carry out decisions not to resuscitate or who, in good faith, refuse to carry out a decision not to resuscitate?

In addition, the union should seek an opinion from the state board of nursing regarding any professional issues that may place school nurses at risk of professional discipline. For example:

- Must the school nurse obtain CPR training if the nurse is responsible for providing care to a student with a potentially life-threatening health problem?
- What is the school nurse's responsibility when a student's private physician issues a valid non-hospital DNR order and the district does not have a DNR policy?
- What is the school nurse's role in implementing a DNR order when the student's health services are provided by a private (Medicaid or insurance reimbursed) nurse?

School instructional personnel (teachers and paraprofessionals) and non-nursing related service personnel have other issues to consider. Some members of the school staff may have moral or ethical objections to complying with a DNR order. Other students in the class may need to be prepared for the possibility of the death of a classmate on school premises. Depending on the age of the students, it may be necessary for teachers or counselors to explain why teachers, paraprofessionals, and school nurses—who they would expect to help their classmates in times of need—are standing by, seemingly idle, while their friend is dying. In some circumstances, teachers and related service providers can show that the emotional trauma to other students is so great that the educational program will be significantly disrupted, and placement in a more restrictive setting may be warranted. School staff and students alike may need emotional support and grief counseling if the order is put into effect on school premises.

If state law allows school district personnel to honor DNR orders, it is the responsibility of the school board to decide how the issue will be addressed in the schools. Ideally, the school district should develop its plan before a request is received so that they can study the issue and make recommendations insulated from the passions aroused by a particular situation. The plan then can be put in place before the question arises. Undoubtedly, the district will receive legal advice before the policy is finalized.

Chapter 4
Non-Nursing School Personnel

School personnel in a number of non-nursing roles have responsibilities for providing educational services to medically fragile students. Teachers, paraprofessionals, bus drivers, and others are responsible for teaching and transporting these students. This chapter is intended to delineate the framework within which these people operate as they strive to meet the educational needs of medically fragile children.

What is the Role of the Teacher?

Teachers are responsible for developing and implementing the instructional program of the classroom. This consists of incorporating district academic standards into classroom practice, being responsible for providing safe and orderly classrooms, serving on IEP teams, and a variety of other activities that support instruction. In order to provide high-quality instructional programs for all students, teachers may have to consult and collaborate with a variety of specialists, including the school nurse, as well as coordinate the work of one or more paraprofessionals. However, it is not appropriate for teachers to provide nursing services for medically fragile children, and only in very special circumstances should teachers provide personal care services. Not only does having teachers provide nursing services raise legal questions, it can be dangerous for the children and take precious time away from the instructional program. In almost every case, the school nurse, or a well-trained and competent health aide working under the direction of the school nurse, should provide such services.

Nevertheless, it is important for the teachers of medically fragile children to work closely with the health professionals who provide services so that students' educational programs take into account the health needs of the students.

What is the Role of the Paraprofessional?

The role of the paraprofessional is to provide support for education in the classroom. This takes many different forms (small-group instruction, completing paperwork, monitoring student activity, etc.). Paraprofessionals have typically worked either in a traditional classroom setting or in classrooms with special-needs students and many work as aides in school health rooms. Until recently, only school health aides and paraprofessionals in classrooms with special-needs students were faced with the possibility of providing health services to students. As more and more students are included into traditional classrooms though, all paraprofessionals and teachers are faced with the prospect of providing these services, which can range from the most basic to extremely complex, invasive procedures.

The health room aides' primary job, in their role as adjunct to the school nurse, is meeting the health needs of students. It is traditionally part of their duties to assist with the provision of health care services to students—but they have the same legal limitations placed on them as other non-medical school personnel. In recent years, we have seen an increase in the use of health room aides, with more and more of those jobs requiring LPN or health assistant training.

All paraprofessionals, both in the classroom and in the health room, work under the supervision of the school principal but their work is generally directed on a day-to-day basis by the classroom teacher or school nurse. As laid out in Chapter 3, in the case of directions to provide services within the scope of nursing practice, paraprofessionals can be delegated tasks only by a registered professional nurse and cannot legally be directed to provide such services by any other person.

What is the Role of the School Bus Driver?

School transportation personnel (bus drivers and bus monitors) are charged with providing safe and efficient transportation for students. Providing that service for special-needs students is more complicated and time-consuming than it is for the majority of students. Some areas of concern include legal requirements, training, emergency procedures, routing, scheduling, and equipment needs.

As with other school personnel, P.L. 94-142 and the IDEA affect transportation services for special needs students. Related items specifically addressed include:

transportation as a related service
vehicle requirements
emergency procedures
IEPs
length of ride
pick-up and drop-off
parent transportation
due process
extended school year

A summary of these provisions from a report by the The Twelfth National Conference on School Transportation Association can be found in Appendix I. In addition, school districts themselves should develop policies or guidelines to cover suspension of services for behavioral reasons as well as student-restraint procedures.

AFT local unions must be prepared to ensure that their drivers receive proper training. A comprehensive list of training program components is included in Appendix I.

Training Needs of School Staff

Preservice and in-service training should be provided for all school personnel. It should be ongoing, systematic, and updated as changes occur in the student population and in the requirements of educational programs. Training programs in the area of medically fragile children should cover the following areas:

1. P.L. 94-142 and Individuals with Disabilities Education Act—history of the acts, who it covers, how it works
2. Section 504 of the Vocational Rehabilitation Act—history of the Act, who it covers, how it works
3. Legal Issues—Nurse Practice Act, Liability
4. Universal precautions—what this means, how they work, how to get help
5. Basic first aid and CPR
6. Emergency procedures for the school—who to call, where to take students in case of fires, earthquakes, power failures, etc.
7. Proper techniques for lifting and moving students

8. Proper use of equipment students might have in school (e.g., wheelchairs, walkers, breathing apparatus, etc.)
9. Overview of typical student health problems that may encounter in the traditional classroom (e.g., asthma, cystic fibrosis)
10. The how-to's of any health care procedures delegated to them by the school health professional including:
    what constitutes an emergency;
    whether the procedure could be a threat to staff members' own health and safety;
    possible reactions or side effects to procedures or medications;
    possible drug interactions; and
    legal and liability issues.

The school health professional's responsibility, if he or she has delegated provision of health services, is to certify that non-nursing school personnel have been appropriately trained to provide those services. It is also his/her responsibility to continually monitor the performance of delegated tasks, and ensure retraining or updated training for persons who have been delegated to do the tasks.

As a further precaution, we also recommend that teachers and paraprofessionals (and all other staff who require training) be sure their training has been documented and signed off by the school nurse or the person who trained them.

Please note: Whether or not non-nursing school personnel are responsible for providing health services, they should still be trained in such areas as proper lifting techniques, emergency procedures, background on federal and state law, etc.

What Is the Liability of School Personnel?

There are legal limitations on school personnel with regard to the provision of health services. As discussed in Chapter 3, every state has a Nurse Practice Act that defines those tasks which are the responsibility of licensed nurses.

- The school health professional (in most cases a school nurse either on site or on call) is **legally responsible** for providing appropriate health services to students.
- The school health professional may delegate the provision of the service if he/she has trained and continues to supervise other school personnel who provide those services.
- But, whether or not he or she has delegated the responsibility, **the school health professional is still legally responsible.**
- Even with this provision, there are still limitations on the types of services non-medical personnel can provide. The matrix in Appendix D outlines more specifically the types of services that different levels of personnel may be trained to provide.

Liability issues for transportation personnel are not as clear-cut as they are for most other school personnel. As a general rule, drivers are not responsible for providing medical services, except in emergencies. They are rarely, if ever, delegated that responsibility, therefore are not usually held liable for problems that occur in the provision of health services. Liability concerns for all drivers (not just those transporting special-needs students) center on operation, use, or maintenance of a vehicle. School district liability policies cover drivers for student injuries in these areas. In most cases, district policies also cover drivers for accidents or injuries to students that are related to their supervisory responsibilities. As an example, one student injuring another by throwing something would be a case of supervision. A student falling on another because a tire blew out would be a case of vehicle use.

(Note: The AFT's liability insurance provides coverage for members only in cases of direct supervisory responsibility of students.)

AFT's Recommendations for Non-Nursing School Staff

The AFT recognizes that teachers, paraprofessionals, and other school personnel have been performing these tasks for many years—in some cases, with extensive training, and in many others, with no training at all. Paraprofessionals and health aides provide a very valuable service by freeing the teacher to take responsibility for education and allowing the school nurse to handle more serious health care needs. This practice should continue where appropriate, but we also believe there are precautions affiliates should take to protect their members.

1. Negotiate requirements for appropriate training programs for all school personnel working with medically fragile students.
2. Educate school staff about the legal limitations placed on them by the state's Nurse Practice Act.
3. Educate school staff about the liability issues they face and the union's ability to protect them.
4. Develop job descriptions that clearly define the role and the responsibilities of the school staff (especially paraprofessionals to whom the responsibility often falls).

Resources

At the school level:

Your school nurse
The child's parents
The child's doctor
The principal
Your union representative

At the district level:

The special education office
Local public health agency
County community health services
Children's hospitals
University specialty clinics

At the national level:

Children's Defense Fund
25 E Street NW
Washington, DC 20001
(202) 628-8787

The Council for Exceptional Children
1920 Association Drive
Reston VA 22091-1589
(800) 232-7323

National Association of School Nurses
P.O. Box 1300
Scarborough, ME 04074
(207) 883-2117

National Information Center for Handicapped Children and Youth with Disabilities (NICHCY)
P.O. Box 1492
Washington, DC 20013-1492
(800) 695-0285

National Resource Center for Paraprofessionals
CASE/CUNY Graduate Center/Room 620N
25 West 43rd Street
New York, NY 10036
(212) 873-8697

Transporting Students with Disabilities
Federal News Services, Inc.
P.O. Box 13460
Silver Spring, MD 20911-3460
(301) 608-9322

Chapter 5
Health and Safety Issues

Providing care and support to medically fragile children presents special health and safety concerns for school staff. In situations where those children require care, school staff are not unlike health care workers As such, they may have greater than usual exposure to communicable and infectious disease. And they may be called upon to lift or otherwise assist children—activities that put them at risk for serious, often disabling, back injury and muscle strain and sprain.

Every school needs a policy that takes into consideration the health and well-being of school staff as well as the health of medically fragile children. A comprehensive policy will incorporate the current Occupational Safety and Health Administration (OSHA) standards, the National Institute for Occupational Safety and Health (NIOSH) recommendations, and Centers for Disease Control and Prevention (CDC) Guidelines. The policy will also evaluate the immunization requirements of staff as well as students and all special precautions for high risk staff, i.e. those with chronic illnesses (diabetes, cardiovascular disease, cancer etc.) (Copies of these standards and recommendations are available from the AFT.)

Below is a review of basic concerns that a school policy should address.

Communicable Diseases

There is growing concern that staff in schools and other institutional settings such as health care facilities may be exposed to certain communicable and infectious disease agents to a greater degree than the general public. For the most part, staff who are healthy and take appropriate precautions are at very little risk of developing diseases from such exposures. However, vulnerable staff—including those who have chronic diseases that may impair their immune systems, and pregnant staff—should be aware of their exposures and take effective measures to protect themselves from infection and disease. Fortunately there are proven preventive precautions, such as hand-washing, that staff can take to prevent or reduce exposure.

I. Blood-borne diseases

Staff members who routinely assist students with toileting, diapering, suctioning mucous, insertion of catheters, and/or administering injections are most likely to come in contact with blood and body fluids. But even those who don't care for medically fragile students are at risk of exposure through accidents, such as a bloody nose.

Because of their work, school staff have begun to wonder about the possibility of contracting blood-borne diseases. Most of the worry has been focused on AIDS. However, hepatitis may be a bigger threat to school staff who are exposed to blood and body fluids. Not unlike health care workers, school staff need to understand what constitutes a blood-borne disease and what to do to avoid exposure.

Human immunodeficiency virus (HIV), hepatitis B (HBV), and hepatitis C (HCV) are the primary blood-borne viruses of concern.

Human Immunodeficiency Virus (HIV)

The human immunodeficiency virus (HIV) is probably the most talked-about virus since polio. Almost everyone knows that it causes AIDS (Acquired Immune Deficiency Syndrome). But there is still a great amount of confusion about the virus HIV and how it is transmitted. It is important to remember that HIV is not spread through hugging or handling a child, sharing clothing, or through food. School staff can continue caring for students in a routine way without fear of infection. Now for some facts:

- It is not unusual for people with HIV infection to go years without manifesting symptoms. However, they can still transmit the infection during this pre-symptomatic phase.
- The HIV is very fragile, even though it can cause death. It cannot survive for a very long time outside the human body.
- The virus is not very concentrated in the bloodstream of an infected individual.
- For an infection to occur, the blood, semen, or vaginal fluid of an infected person must find its way into the blood of a non-infected person.

These facts help us understand why in the overwhelming majority of cases the virus is transmitted through sexual intercourse, contaminated needles, or from mother to child during pregnancy or breast-feeding. This knowledge also explains why the virus continues to spread through a population.

The only documented cases of transmission of HIV in a work setting have occurred in hospitals or health care facilities. The majority of those cases involved a needlestick injury with a contaminated needle. There are no documented cases of transmission in a school setting.

Over the last 14 years (1981 through October 1995), a total of 6,817 cases (1.4 percent of all cases) of AIDS have been reported among children 13 years or under in the United States. No one knows how many children are infected with HIV, but as of 1993, the Centers for Disease Control and Prevention projected that 10,000 children were HIV-positive.

Relatively speaking, these numbers are fairly small. Most school staff will probably never encounter an HIV-infected child. But in the rare event that a child might be infected, school staff can take very simple precautions to protect themselves.

The rule of thumb for school staff and health care workers is to treat everyone the same and use barriers (gloves/masks/gowns) to prevent contact with any blood and body fluids. These techniques are called universal precautions (see section below for details).

Hepatitis B (HBV) and Hepatitis C (HCV):

Of greater concern to school staff who deal with medically fragile children and other populations with a high incidence of hepatitis B is the possibility of contracting blood-borne hepatitis, a serious disease of the liver. The two viruses that can cause this disease are hepatitis B virus (HBV) and hepatitis C virus (HCV) (formerly non-A, non-B hepatitis). The rate of HBV and HCV infection among children who have been institutionalized is far greater than average.

Nearly 300,000 new HBV infections are reported every year. Between 30 and 40 percent of all infected adults develop a serious condition. Between 1 percent and 3 percent of those will die from the infection. Symptoms include fatigue, loss of appetite, weakness, jaundice, liver enlargement and tenderness. As many as 5 to 10 percent become chronically infected, which means that while symptoms may subside or even disappear, the virus remains active, and therefore infectious, in their bodies.

We know more about hepatitis B than hepatitis C, but they are transmitted in the same fashion: through sexual intercourse, contaminated needles, and from mother to child during pregnancy.

Although the routes of infection are similar to HIV, there are some differences between HIV and the hepatitis viruses that make HBV and HCV more dangerous in the workplace:

- HBV and probably HCV are more concentrated in the bloodstream of infected individuals (which makes these viruses more contagious);
- unlike HIV, HBV can survive for periods of one week or more outside the human body (e.g., in dried blood); and
- transmission of HBV through saliva and a deep human bite have been documented (this is not the case for HIV).

The potential for infection in a work setting is greater for these viruses. As with HIV, the best protection against hepatitis infection is to assume the presence of infection and employ universal precautions.

Fortunately, there is an effective vaccine (Heptavax) against hepatitis B. This should be offered to any school employee who routinely comes into contact with blood and body fluids.

What Are Universal Precautions?

Universal precautions are simple methods to create barriers between a care provider and a student's blood and body fluids. Among other things, these precautions call for:

1. Protective equipment. Staff who may come in contact with blood and body fluids should wear gloves (preferably latex). When there is potential for splashes of large amounts of blood or body fluid, staff should have gowns, goggles/face shields/masks, and any other effective barriers.
2. Puncture-proof containers. Any school staff member who administers injections should have puncture-proof containers to dispose of contaminated needles. Contaminated needles transmit HIV and the hepatitis viruses.
3. Disinfectants to kill the viruses. To clean up spills, staff should have disinfectants readily available, including common household bleach diluted with water (1 part bleach to 10 parts water), which has been quite effective in killing HIV and the hepatitis viruses.
4. Discarding items and articles contaminated with blood.
5. Adequate facilities and opportunities for school staff to wash their hands immediately after an exposure. Washing the hands immediately after exposure has been documented to be the most effective method of preventing exposure and transmission of a large number of disease agents. However, in many school settings, staff have very little access to sinks and running water. Having hot and cold running water in the classroom or immediately adjacent must be a priority in a setting with medically fragile children.. When it is impossible to have facilities available (e.g., on the bus), sanitary wipes should be readily available.

Every school employee who could be exposed to blood and body fluids should receive detailed training on transmission of the viruses, health effects, and all the necessary universal precautions to avoid infection.

The OSHA Blood-borne Disease Standard

The AFT, in conjunction with other unions and concerned groups, has worked tirelessly to effect mandatory OSHA standards on universal precautions. OSHA finally developed a legal standard that requires school districts and other public employers in certain states[1] to adopt a comprehensive program to protect their staff against blood-borne pathogens.

The key provisions of that standard call for employers to:

- **develop an exposure-control program** to identify tasks that potentially expose workers to blood and body fluids and develop appropriate training to protect staff;
- **provide training and equipment,** such as gloves and gowns, face shields, puncture-proof containers for needles; and
- **provide hepatitis B vaccine** free of charge to any

Alaska, Arizona, California, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, Oregon, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virginia, Virgin Islands, Washington, and Wyoming.

employee who is likely to be exposed to blood and body fluids.

This standard went into effect in stages. After May 5, 1992, employers were to have completed their exposure control program. AFT affiliates and/or individual school staff are entitled by law to be supplied a copy of this program upon request. Contact your school district for a copy of their exposure control program.

AFT affiliates who lack coverage through an OSHA state plan should consider using the national OSHA standard as a model for health and safety contract language (copies are available from the AFT).

II. Other Communicable Diseases

School employees working with medically fragile children are apt to be exposed to other communicable disease agents in addition to bloodborne diseases. Children with chronic illnesses are often more susceptible to infectious diseases than other children and may be disproportionately affected by infections that spread through the schools. Their infections increase the risk of exposure to staff who care for them as well. Notable examples include:

Impetigo

Impetigo is a common skin infection among children; it is generally caused by the bacteria staphylococcus and less often by the bacteria streptococcus. It appears as a cluster of raised bumps filled with fluid that often contain pus. The infection can occur anywhere on the skin but is very common on the face.

Impetigo is highly contagious for young children and children with chronic illnesses. Staff with chronic conditions such as diabetes and cancer are also especially susceptible. The disease is spread through direct contact with the sores of an infected person; it is also easily transmitted through contaminated towels and other toilet articles. Impetigo usually requires antibiotic therapy.

Ringworm

Ringworm is a general name for several fungal skin diseases. The most common ringworm found in school are ringworm of the scalp (tinea capitis), which causes scaly patches of temporary baldness, and ringworm of the body (tinea corporis), which causes flat ring-shaped sores.

Animals such as cats and dogs as well as infected people can transmit the fungus. It is very easy to transmit the fungus through direct skin-to-skin contact. Indirect contact with contaminated combs, hats, hair brushes, clothing, toilet articles, and shower stalls can also result in infection.

Ringworm can lead to other more serious bacterial infections if it is not treated promptly. Eliminating ringworm from schools requires a concerted effort to identify and treat infected students immediately and also to treat potential sources (e.g., pets).

Tuberculosis

Tuberculosis (TB) was once in such decline in the United States that the Centers for Disease Control and Prevention thought the disease could be eliminated by the end of the century. Unfortunately, the reverse has occurred. TB is on the rise in major urban areas associated with new immigrant populations, the homeless, and HIV-positive individuals.

Children in large urban areas—especially those with chronic illnesses—are very susceptible to TB infection. Active TB often has vague symptoms of fatigue, fever, and weight loss. Many physicians in this country do not have experience with diagnosing TB in adults or children.

Young children (under adolescent age) generally do not have the same form of the disease as adults. They generally do not cough and usually do not have many bacteria in their lung secretions. However, there is documentation that older children can have the adult form of the disease and have the tubercle bacteria in their saliva. When they cough and sneeze, they release droplets containing the bacteria into the air. Other students and school employees who inhale these droplets can become infected.

If a case of tuberculosis is discovered in a school, the district should work closely with the local health department to put the appropriate screening and education/information programs in place to protect students and staff alike.

Bacterial Meningitis

Any bacteria can cause meningitis, but the most common meningitis in this country is caused by Neisseria meningitidis (meningicoccal meningitis).

Most cases of meningicoccal meningitis occur in the winter and spring. Although a disease of very young children, it occurs in both children and adults and more frequently in males than females. Bacterial meningitis strikes 6 in 100,000 persons in the United States every year; two-thirds of the cases involve children under age 5. In the 1990s, most cases in this country have been associated with crowded living conditions, schools, and other institutional settings.

The symptoms of the disease include sudden onset of fever, intense headache, nausea and often vomiting, a stiff neck, and frequently a red rash with minute spots. Delirium and coma often follow. Fortunately with early diagnosis and treatment, the case-fatality rate has fallen from 50 percent to between 5 percent and 10 percent.

The bacteria is usually transmitted through contact with droplets from the nose and throat of an infected individual. New infection in most individuals will only cause an infection of the mucous membranes with no symptoms of disease (subclinical). A very small number of individuals develop the life-threatening disease.

Susceptibility to the disease is low and decreases with age. However, certain individuals with immune system problems and/or who have had their spleens removed may be at increased risk of illness.

The best way to avoid infection with the bacteria is to reduce crowding in classrooms and to educate personnel so that infected individuals are identified and treated early. When a case has been identified, the school should work closely with the health department to monitor students and staff who may have been exposed for early signs of illness such as fever and headache. The health department officials may recommend preventive treatment with an antibiotic for staff and students who have very close contact with a case, e.g., a staff person who physically handled a student with meningitis or a friend who shared eating utensils.

Pediculosis (Head Lice)

Head lice infest up to 12 million children in the United States every year—mostly children in kindergarten through the eighth grade. Adult lice (about the size of a small seed) attach themselves to the scalp where they bite and suck blood. They reproduce rapidly; a single adult female produce three to four eggs or nits per day, which she glues to the base of hair shafts with a sticky substance. Eight to ten days later, the nits hatch into immature lice, called nymphs. The nymphs become adults in another eight to nine days.

Head lice aren't spread by cats and dogs but by other people. They don't fly or jump, but they can be transferred when infested personal items such as hats, combs, and scarves are shared. They can also crawl from someone's head onto pillows and chairs and from there crawl to another person's head.

The first symptoms are itching of the head and scalp. It may take as long as two to three weeks before a person experiences the intense itching associated with infestation. Any itching around the ears or the back of the head is a possible clue that head lice have infested the scalp. The hair should be examined for head louse eggs (nits) on the hair.

Staff should be trained on the life cycle of lice and on effective methods for inspecting children's heads for nits. Staff also should limit contact with students who are infested and with their personal belongings. Staff who become infested should:

- wash their hair with a special head-lice shampoo (shampoos with pyrethrins are available over the counter; others with lindane require a physician's prescription)
- take all the nits out of their hair using a special comb with very finely spaced teeth—any nits left can start the infestation process over again
- wash sheets and clothes in hot water (130(F)
- repeat the process seven to ten days later to insure that no eggs have survived

Pneumococcal diseases:

A bacteria called Streptococcus pneumoniae is an important cause of ear infections (otitis media) in children, pneumonia, and other infections. The bacteria are normally found in the upper respiratory tract. When a young child has an active infection, he or she can transmit the disease through droplet spread (i.e. sneezing, coughing, laughing) or through articles freshly contaminated with respiratory discharge. Healthy children and staff are not at great risk of infection. However, staff or children who have other acute infections (e.g., a cold, flu) or who have chronic illnesses (diabetes, heart disease, cancer, etc.) are at greater risk of infection when exposed.

Staff with chronic illnesses are at risk for pneumonia when exposed. They may suffer a sudden onset of shaking, chills, fever, and coughing.

Unfortunately, this bacteria is becoming more resistant to penicillin and other antibiotics. Studies have shown that in some populations of infected children up to 30 percent of isolated bacteria are resistant to penicillin and other drugs. Because we can't take antibiotic treatment for granted, it is important to exercise all the universal precautions above to prevent transmission of the diseases.

Staff and students who are in the high-risk category should discuss vaccination with the Pneumococcal vaccination. This relatively safe vaccine might spare a vulnerable staff member from a deadly infection or substantially reduce any illness after exposure.

A School Approach to Communicable and Infectious Diseases:

Every school should have a comprehensive communicable disease policy. School districts should keep in touch with their local health departments in order to determine which communicable diseases are prominent in their community. Once a list is identified, a school system should use the OSHA exposure control plan in the blood-borne disease standard as a model to control exposure by staff and students in their school. Such a policy should at a minimum provide:

- training and updating of school staff on their risk as well as the risk to their children of communicable diseases and preventive measures that should be taken;
- a comprehensive immunization program for staff and students; for instance, influenza vaccine should be offered to staff to reduce the number of respiratory illnesses during the year and hence improve attendance rates;
- treatment for infected staff and payment through worker's compensation (there should be a presumption that staff infections are work-related);
- a plan to deal with outbreaks of infectious diseases that keeps staff informed of procedures which should be taken during the duration;
- information for pregnant school staff that explains how to safeguard the fetus against harmful exposure and protection that provides medical removal with full pay and benefits in the event a pregnant employee must leave the school setting; and
- written information sent to parents on the appropriate measures to take at home with a child who is infected or infested.

Muscle Strains and Sprains

Children who need constant physical assistance are a special challenge to school staff. One AFT paraprofessional recently reported that he "nearly spent the entire day in the bathroom" assisting four students in wheelchairs with toileting. The constant lifting from that day and many others has left him with chronic lower back pain.

Lower back pain is a clear warning of a severe problem. Individuals with constant back pain are at far greater risk of experiencing a serious back injury. These injuries are termed "cumulative trauma" injuries because they result from months or years of wear and tear on a person's back. Such an injury could occur on the job or at home. In either event, it is clearly a work-related injury.

This teaching assistant's story is not unusual. A teacher, teaching assistant, school nurse, or bus driver who constantly lifts or twists his or her back may likely experience an injury. Shortages in

Tips for preventing back injuries in classroom personnel who handle medically fragile children

Tip #1: Pay attention to chronic/reccurring back pain

People who suffer from chronic back pain are more likely to suffer a serious back injury than people who do not. Remember that most back injuries are an accumulation of daily wear and tear on muscles, discs, and ligaments.

Consider back pain an alarm not to be ignored. Seek good medical advice before it escalates into a major injury.

Tip #2: Never manually lift students by yourself

Remember that the weight of almost all students far exceeds the lifting strength of most workers; lifting students produces incredible forces or "strains" on the lower back.

Unfortunately "lifting techniques" are not useful when handling students; students' bodies are bulky loads with "no handles" and a lifter can't bring that load close enough to the body to reduce strain.

Tip #3: There are ways to manage students in the classroom setting

Research in the health industry has indicated that teamwork is essential when handling patients; this research can easily be applied to a school setting.

When transferring students (e.g., for toileting), teams should use lifting devices such as walking belts that are worn by the student. Walking belts have handles that allow staff to get a good grip on the student without hurting the student or risking injury to the staff person. Walking belts are used when the student is not too heavy (under 150 pounds) and can bear some of their own weight.

When a student is too heavy and cannot provide assistance during a transfer, mechanical devices are crucial.

Tip #4: Every school should have a program of training and task redesign to prevent injuries

Essential elements of the program should include:

- assessing the physical layout for furniture and equipment that must be used in awkward positions (recommendations should be made for change when equipment such as changing tables are too low and force staff to squat or bend excessively);
- identifying the most stressful tasks;
- selecting one stressful task at a time to redesign;
- training all staff on the use of new equipment or techniques that are in the redesign program; and
- maintaining all equipment and assistive devices.

staffing can make the problem worse. Whenever one staff person must lift a student alone, the risk of injury increases significantly.

The bad news is that these injuries can lead to chronic, disabling problems that might force a school employee to leave his or her job. These types of injuries cost school districts and other employers a substantial amount of money in lost time, worker's compensation, and lower productivity. The good news is that these injuries can be prevented through good techniques, equipment, and above all, training.

Resource

For copies of AFT Occupational Safety and Health resources, Federal OSHA standards, CDC guidelines, and NIOSH recommendations contact:

Darryl Alexander
American Federation of Teachers
Occupational Safety and Health Coordinator
555 New Jersey Avenue NW
Washington, DC 20001
202-393-5674

Chapter 6

Coping in the Classroom

Here are some things to consider and tips for coping in your classroom:

■ OBSERVATIONS AND DOCUMENTATION:

Put relevant information in writing. The teacher and classroom assistant are the first line of information in the educational setting. Written observations of behavior and changes in behavior can be communicated in an accurate and timely manner to the rest of the team. A checklist is useful for routinely monitoring ongoing and changing student needs.

■ EMERGENCY PROCEDURES:

Make sure you have a superior emergency and fire protection system in place and posted for all to locate and understand. Make sure that all students understand the warning signals and your procedures for what to do and who is responsible. Have a plan for transporting students with limited mobility out of the building in case of fire. Make sure switches, controls, and fire alarms are within reach of students in wheelchairs. Find out what types of emergencies might occur as a result of equipment failures.

■ ACCESSIBILITY:

Try to make the classroom as barrier free and accessible as possible. Don't block doorways or put sharp or breakable items in doorways or aisles. This is especially important in case of emergency.

■ APPROPRIATE EQUIPMENT:

You need to make sure your classroom is appropriately equipped for the needs of the medically fragile child. The equipment should be easily accessible. You need to consider its placement and the safety of the others in the room. The equipment needs to be routinely monitored and maintained.

■ SUPPLIES:

Where will equipment and supplies be obtained? Is there a plan for parents to send disposable supplies to school on a regular basis?

■ CLASSROOM FURNISHINGS:

The furniture in your classroom should allow for the students' health care needs, as well as general accessibility for the disabled.

■ ACCESS TO ELECTRICAL POWER:

If your student needs electrically powered equipment, both make sure that you have access to the necessary electrical outlets and that there is backup electrical power in case of a power failure in the school.

■ CLEANLINESS:

Classrooms should have sinks to provide for the sanitary and safe provision of services. Handwashing, of course, is crucial to preventing the spread of infection. Hands should be washed before and after contact with the student needing medical care. Is the classroom cleaned daily? Also pay attention to the type of cleaning materials used and possible allergic reactions.

■ PROTECTION:

Use disposable gloves for protection when providing services requiring contact with blood or body fluids. This is essential for protection of the caregiver as well as to control the spread of infectious agents from student to student. Hands should be washed after removing gloves.

■ ACCIDENTAL EXPOSURE:

Risk of exposure to blood or body fluids depends on the type of body fluid, the type of infection, and the condition of the skin. Project School Care publication (see Readings and Resources) recommends washing the contaminated area immediately with soap and water. School districts should have a policy regarding exposure to blood and body fluids, including a post-exposure program. The individual should contact their union regarding the incident in case there is a worker's compensation case.

■ CLEAN-UP:

Project School Care recommends that spills of blood and body fluids should be cleaned up immediately. The CDC recommends the following method: (1) wear gloves; (2) mop up the spill with paper towels or other absorbent material; (3) using a solution of one part household bleach in 10 parts water, wash the area well; and (4) dispose of gloves and waste in a sealed double plastic bag.

■ WASTE DISPOSAL:

Have a system for disposing of waste. Project School Care recommends that contaminated supplies (except for sharp objects) be placed in sealed plastic bags and then sealed in a second plastic bag before disposal. Sharp objects should be placed in puncture-proof containers.

■ MEDICATION:

You need to know about medication being taken by the student. What are the effects? Are there any possible side-effects? What happens if the medication is not taken? If at all possible, medicine should be given at home.

■ TOILETING:

A bathroom should be accessible to the physically disabled, with space and hardware to permit independence. Sinks and faucets should be low and easy to operate. A procedure for taking the child to and from the bathroom should be established.

■ PRIVACY:

Each child deserves the right to privacy, especially for health procedures that are invasive or could be embarrassing if performed in front of other children.

ADDITIONAL CONCERNS

Some additional questions to ask:

When should the teacher inform the school nurse of observed changes?

Is there a specific set of symptoms to indicate the need for emergency procedures?

How does the child's medical problem affect his mobility/physical movement? What are necessary restrictions?

Are there any procedures that the parents have authorized the child to perform?

What kind of medical crisis can occur while using certain equipment?

Chapter 7
Solutions/Further Steps

The Union Contract

Many AFT locals have addressed the concerns surrounding the issue of providing health services to students using one of their most powerful tools—their union contract. AFT locals have negotiated contract language addressing everything from dispensing medication to student/nurse ratios to liability concerns.

We have included some sample clauses to give you an idea of the issues addressed. **Please be aware that these clauses were achieved through the collective bargaining process and should be viewed as examples of subject areas, not textbook models of contract language.**

NURSE RATIOS

A full time nurse shall be assigned to each large school to care for children who become ill and to carry out a program of health education through lecture and demonstration.

—Nashua Teachers Union, #1044, N.H.

Nursing service shall be available to each elementary school either at the school or on call.

—Kansas City Federation of Teachers, #690, Mo.

An adequate number of school nurses shall be provided to serve each school building.

—Lancaster Teachers Association, #2778, N.Y.

NURSING DUTIES

It is understood between the Board and the Union that responsibilities of the registered nurses are those which would normally be included within the work duties of a registered nurse. Except in the case of a school or system emergency, no registered nurse will be required to assume responsibility of a classroom or the work of another bargaining unit.

—Hartford Federation of School Health Professionals, #1018, Conn.

No employee shall be required to perform complex nursing interventions without having first been cleared to do so by the school nurse, in accordance with the Nurse Practice Act, La. R.S. 46:3703 et seq.

—United Teachers of New Orleans, #527, La.

MEDICATION/MEDICAL SERVICES

Medication is not to be dispensed by a BOCES teacher aide.

—SAS BOCES, N.Y.

Clericals shall not be required to administer first aid to an injured pupil.

—United Teachers of New Orleans, #527, La.

The administering of prescription medication to students by employees, other than health care aides, shall be on a voluntary basis. Employees shall respond to emergency situations and accidents by providing care and comfort until help arrives. Ongoing health intervention such as suctioning, catheterization, and tube feeding shall not be the responsibility of the employee.

—*North Chicago Classified Staff Union, #504, Il.*

—*Waukegan Office Workers Council, #504, Il.*
—*Waukegan Paraprofessional Council, #504, Il.*

A Health Care Delivery Study Committee shall be formed consisting of four (4) members appointed by the Union President (i.e., a clerk, secretary, teacher, school nurse) and four (4) members appointed by the Board (i.e., two board members and two administrators). The tasks of the Committee shall include:

1. A study of the current health care delivery model, including time spent by employees.
2. A review of current Board Policy as it affects health care delivery.
3. Drafting and recommending any changes in policy or delivery of health care services for consideration by the Board.

—*Woodland Support Staff Council, #504, Il.*

TRAINING

All elementary and middle school secretaries involved in the dispensing of First Aid services shall receive a two-hundred dollar ($200) annual stipend. Such stipend shall be paid with the last check of each month for the months September through June.

All elementary and middle school secretaries involved in the dispensing of First Aid services shall receive appropriate and periodic training as part of the in-service program.

—*Norwalk Federation of Education Personnel, #1723, Conn.*

Primary consideration in making any assignment shall be based upon the competency, training and experience of the unit members for the undertaking.

—*Newark Teachers Union, #481, N.J.*

LIABILITY

Students who are known to have health problems, who are on medication, who are emotionally disturbed, or who are known to be severe disciplinary problems shall not knowingly be assigned to any bargaining unit member without first apprising him or her of the facts regarding each case. Employees shall be required to retain all information on student problems in the strictest confidence.

—*Windsor Office Personnel and School Aides, #3807, N.Y.*

HEALTH AND SAFETY

A paraprofessional whose job description requires toileting students shall be provided with disposable protective gloves. Disinfectant soap shall be supplied in all facilities in which paraprofessionals toilet students.

—*Toledo Federation of Teachers, #250, Ohio*

ADDITIONAL AREAS

The following areas also are appropriate to cover in a contract:

1. Allowing for voluntary placements to work with medically fragile children;
2. Having the district provide both general and child-specific training by qualified and properly prepared health care professionals for staff who volunteer to work with medically fragile children;
3. Having the district provide hepatitis B immunization for staff;
4. Having the district provide emergency and CPR training for staff;
5. Giving classroom personnel access to health professionals via portable phones;
6. Having the district and staff develop emergency back-up evacuation and ambulance plans for staff;
7. Having the district provide emergency power provisions (for suctioning, ventilators, etc.);
8. Defending staff from lawsuits when they provide care for medically fragile special education students;
9. Procesures in the case of DNR orders.

Legislative Programs

A second means of addressing this issue is through enactment of state legislation that more definitively outlines the roles and responsibilities of school employees. Proposed legislation introduced at the state level over the past few years can be grouped into five main categories:

1. School nurse/student ratios
2. Mandated health services
3. Employment requirements for school nurses
   -requiring registered nurses for schools
   -school nurses as certified teachers
4. Defining specialized health procedures and authorizing personnel to perform those procedures
5. Liabilities issues for school employees

It is difficult to create "model legislation" because laws are different in every state. Recommendations can be made to state federations on subject areas to be addressed by providing examples of proposed legislation from other states.

Appendix C includes copies of the bills referred to in the case study below.

Case Study

Paraprofessional members of the Louisiana Federation of Teachers approached the state federation in 1989 about the problems they encountered with taking care of medically fragile students in the classroom. Their primary concern was catheterization. The LFT surveyed other locals and found that this was a problem throughout the state. They put together a committee and working with their attorney and a nurse attorney, drafted legislation to address the problem. The bill was introduced and passed during the 1990 legislative session with no controversy. Soon after, school districts began the process of training 2 paraprofessionals in each school to perform this procedure.

The LFT soon realized that they needed to respond to the problem of other non-complex medical procedures, and went through the same process on a second piece of legislation. Again, the bill passed easily. Again, school districts began the training process for paraprofessionals. Teachers were specifically left out of both pieces of legislation because they had not traditionally performed these jobs in schools in Louisiana.

A few years later, a group of school nurses approached the state federation about the growing problem of untrained personnel dispensing medication. The LFT approached the State Board of Nursing and formed a coalition to draft and submit a third piece of legislation to address this problem. This time around, the process was not as simple. The coalition faced growing objections from school districts because this bill (as well as the first two) was an unfunded mandate. School districts would be required to train personnel but were not given the funding to do this. School boards attempted to change the legislation to allow for the use of LPNs to dispense medication but were unsuccessful. The final legislation called for a joint effort of the State Board of Nursing and the State Board of Elementary and Secondary Education to produce a manual for use in the schools. The final document is a whopping 600 pages, and the effort to produce the manual was "a nightmare."

An effort was made in 1995 to repeal both the administration of medication and the non-complex medical procedures legislation. The repeal failed because of the efforts of the LFT and the State Board of Nursing.

What Did They Learn?

1. Know what you want before you start. It may be time-consuming to interview and survey members, but it might result in a piece of legislation that addresses a broader range of issues.
2. Know who your supporters are and why they might support you.
3. Know who your opponents are and why they might oppose you.
4. Build coalitions with groups that want the same things. Use their expertise and influence.

Regulatory Bodies

Which agencies or regulatory bodies have authority over the provision of care to medically fragile children in a school setting? Different facets of that responsibility may, in fact, be shared by a number of state bodies—the Health Department, the Board of Nursing, the Department of Education—which makes it harder to clarify lines of authority within the school. The best way to sort out the problem would be to have all the relevant parties agree on guidelines and appropriate responsibilities for the delivery of care. That's what happened in the following case study, although not until the teachers' union, the New York State United Teachers, was able to put pressure on the Department of Education for a solution.

Case Study:

Teachers and paraprofessionals in New York state were frustrated by the lack of clear and authoritative guidelines on the performance of medical procedures in the school. Should they follow the principal's directives, or should they go to the school nurse for advice? Who was responsible? When teachers in one school were asked by their principal to do a nasogastric tube feeding, which they felt was beyond their capacity, they decided to contact their union's state federation for help.

After the union confirmed that, in fact, that particular procedure should be performed by a registered nurse, the union representatives arranged a meeting at the state level between all the organizations, associations, and regulatory bodies that might be involved in the care of medically fragile children. The meeting was convened by the New York State Department of Education.

The school nurses represented by the union were particularly pleased about the prospect of such a meeting. They had written to state nursing authorities years before in an unsuccessful attempt at clarification and had found little understanding of the challenges currently facing school nurses. With the extra political clout of the teachers, they knew there was a better chance their concerns would be heard.

When the meeting finally took place, it was attended by union attorneys, school nurses, and representatives from the State Board of Health and various nursing organizations as well as the Department of Education. The school nurses' early impression that there was little understanding of current conditions in the schools was confirmed. Most of those present had never heard anything like the stories the nurses had to tell about the level of medical complexity now being attended to in the schools. According to a school nurse who was present, the other participants "were shocked. They had no idea. They needed to actually hear the stories from direct caregivers to understand the full impact of what was going on."

As a result of the meeting and subsequent follow-up discussions, a memo was sent out from the Department of Education to all school principals and district superintendents laying out clear guidelines for which tasks must be performed by Registered Nurses or Licensed Practical Nurses, which tasks could be delegated by a nurse, and which tasks could be performed without the supervision of a nurse. (See Appendix D.) Because the memo came from the State Department of Education, it was seen by school administrators as having the force of law, whereas a similar memo by the State Board of Nursing might not have received equal attention.

Now, as the school nurses put it, "we have a tool...something in black and white that we can show to principals to make sure decisions about medical care are made in an appropriate manner."

What they learned:

1. Your first job is to educate the audience. Don't assume people understand what's going on in the schools these day. Most have no idea of the difficult medical problems children may bring to school with them. Most think of the school nurse as someone who hands out pills and takes temperatures. Be prepared to do basic education about current conditions.
2. Involve the state Department of Education or whatever other governing body that your principal or superintendent deems important. For school officials, directives from nursing bodies don't have the same force as those from the Education Department.
3. Cast a broad net when you're looking for allies. If you're able to demonstrate that a diverse group of organized constituencies cares about the issue, important individuals and decision makers throughout the political process will pay more attention to you.

Readings and Resources

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Appendix A
Policy Statements

1. AFT Resolution on Training and Resources for School Employees Working with Medically Fragile Children.

2. AFT Resolution on Inclusion of Students with Disabilities.

3. FNHP Policy Statement on Safe Delegation.

AFT Resolution: Training and Resources for School Employees Working with Medically Fragile Children

WHEREAS, the number of students in classrooms who can be designated medically fragile has increased by more than 17 percent in the last 10 years, and those numbers will continue to rise as the mandates of the Individuals with Disabilities Education Act are fully implemented in the schools; and

WHEREAS, the facilities that have in the past provided educational services for special-needs students, including those identified as medically fragile children, usually had full-time, on-site, trained health care providers; and

WHEREAS, as special-needs students have been moved into traditional classrooms, these health care providers have frequently been laid off rather than transferred to these settings; and

WHEREAS, this loss of health care personnel has forced more and more untrained school personnel to take on responsibility for providing health/medical services; and

WHEREAS, the provision of health/medical services legally falls within the scope of the school health professional employed by or assigned to a facility, unless he/she has delegated that task to a person he/she has trained to perform the procedure/service:

RESOLVED, that the AFT continue to disseminate information to local and state federations about the legal rights and responsibilities of all school employees with regard to provision of medical services; and

RESOLVED, that AFT locals work to educate policy makers and the general public about the need to increase the numbers of school health personnel so that educational personnel will not be required to perform medical/health procedures; and

RESOLVED, that AFT locals work to guarantee appropriate training for all personnel who may want to take on that responsibility and are delegated the task of providing health/medical services to students; and

RESOLVED, that AFT locals work with state federations to enact legislation that will increase the number of school health professionals, mandate appropriate training standards and provide funding for necessary equipment to ensure a safe and healthy environment for students and employees.

1992 by the AFT Convention

AFT Resolution: Inclusion of Students with Disabilities

AFT Resolution on the policy known variously as inclusion, full integration of students with disabilities, the regular education initiative, unified system, or inclusive education.

WHEREAS there is no legal mandate or consistent definition for "inclusion," let it be known that for AFT policy we define inclusion as the placement of all students with disabilities in general education classrooms without regard to the nature or severity of the students' disabilities, their ability to behave and function appropriately in the classroom, or the educational benefits they can derive.

WHEREAS the mission of the public schools and of the AFT is to provide high standards, rich and challenging classroom experiences, and maximum achievement for ALL students, including students with disabilities as well as non-disabled students in general education classes;

WHEREAS public schools, particularly in urban areas, already are facing severe burdens because of the inequities in funding that plague them, overcrowding, the persistent social problems that surround them, and demands that they resolve the immense problems that students bring to school, severely reducing the schools' ability to provide a high quality educational program for any student;

WHEREAS two years before the twentieth anniversary of the passage of the Education for All Handicapped Children Act (P.L.94-142), Congress' continuing cynicism in funding the mandates of the law at under 10 percent of costs instead of the 40 percent promised has compromised schools' ability to provide appropriate services to students with disabilities, and has placed even greater strains on education generally by requiring that higher and higher percentages of funding go to special education;

WHEREAS inclusion is being championed as the only placement for all students with disabilities by a movement of some advocacy groups-in the face of opposition from the parents of many students with disabilities and many respected advocates for the disabled-when there is no clear evidence that inclusion is appropriate or provides an educational benefit for all students with disabilities, and no clear evidence of its benefit for the other students;

WHEREAS there are deep concerns about the high percentage of minority children in some classes for students with disabilities, and inclusion is viewed by some advocates and parents as the only means of getting minority children out of those classes;

WHEREAS inclusion is being adopted by a large number of local school boards, state departments of education, legislators, and other policymakers all over the country as a means to save money by placing all students with disabilities in general education classrooms and curtailing special education supports and services;

WHEREAS inclusion is being adopted in contradiction to the mandates of P.L.94-142 and the Individuals with Disabilities Education Act (IDEA, the revision of P.L.94-142) that require students to be evaluated and, based on individual needs, assigned to the "least restrictive environment" (LRE) that exists within a continuum, or range, of placements;

WHEREAS even when students with disabilities are appropriately placed, general and special education staff who work with them are not receiving the training they need that they are entitled to by law;

WHEREAS the federal law and court decisions forbid school districts from removing disruptive students with disabilities from programs for more than 10 days a year, and require that, in the absence of school district and parental consent to an interim placement or a court order, such students "stay put" in the class while their placement is being evaluated and adjudicated;

WHEREAS the existing federal legislation limits the ability of teachers to challenge legally inappropriate placements of students with disabilities in general education classrooms;

WHEREAS insufficient medical personnel are employed by school districts to care for medically fragile children under existing circumstances, and inclusion would place these students in medical danger and increase the responsibilities of teachers and paraprofessionals;

WHEREAS inclusion threatens to overwhelm schools and systems that are already extremely vulnerable-particularly in areas with great poverty and social needs-by placing additional responsibilities on teachers, paraprofessionals, and support professionals, thus threatening the ability of schools to meet the educational needs of all students;

WHEREAS students with disabilities have frequently been placed in programs that failed to serve their needs to meet high educational standards, fueling the desire of their parents to have their children in general education classrooms even when such placements are not appropriate;

RESOLVED that the AFT continue to seek high, national achievement standards for education, applicable to ALL students, disabled and nondisabled alike;

RESOLVED that the AFT oppose inclusion-that is, any movement or program that has the goal of placing all students with disabilities in general education classrooms regardless of the nature or severity of their disabilities, their ability to behave or function appropriately in the classroom, or the educational benefits they and their general education peers can derive;

RESOLVED that the AFT denounce the appalling administrative practices that have accompanied the inclusion movement. These include, but are not limited to, placing too many students with disabilities in individual general classrooms; placing students with disabilities in general education classrooms without services, professional development, or paraprofessional assistance; refusing to assist teachers who are having problems meeting the unique needs of students with disabilities; and changing IEPs en masse so that students with disabilities may be placed in general education classrooms without supports and services and irrespective of the appropriateness of the placement;

RESOLVED that the AFT seek alliances with organizations that support the continuum of alternative placements and the educational placement of students with disabilities within the least restrictive environment appropriate to the individual needs of the students;

RESOLVED that the AFT seek with its allies to reopen P.L. 94-142 and IDEA, convincing Congress both to recognize in the law the high costs and complex problems of special education, and to respond by providing:

1. full funding for all of its mandates;
2. a 5-year reauthorization of the laws for educating students with disabilities-just as every other education act requires-to realize the benefits of new hearings and discussions of problems that arise;
3. the legal right for teachers to attend the IEP meetings of children they teach; the right to appeal inappropriate placements; and the right to be fully represented during due

process hearings without reprisal, i.e., intimidation, coercion, or retaliation, for being a child advocate; and the right to be involved in the assessment of delivery of services, staff training, and availability of resources to ensure the effectiveness of the program as intended by Congress;

4. the reauthorization and enforcement of the continuum of placements, which includes mainstreaming as an existing alternative strategy within the range of services for students with disabilities;

5. that criteria for placement in general education require the proximate ability of students to function appropriately both academically and behaviorally when supplementary aids and services are provided by the district;

6. support for districts in maintaining consistent discipline policies for ALL students who disrupt classrooms or engage in dangerous behavior;

7. reauthorization of and insistence on comprehensive professional development;

8. negation of court decisions concerning students with disabilities which are detrimental to educational programs-such as the "stay put" provision, limitations on the discipline of students with disabilities, and decisions that favor inclusion;

9. for limitations on the number of students with disabilities in self-contained and general classrooms;

RESOLVED that the AFT seek with its allies to address the problem of the high percentages of minority students in special education; and

RESOLVED that the AFT renew our longstanding commitment to meeting the needs of ALL students for high standards, rich and challenging classroom experiences, and maximum achievement, whatever their educational placements might be.

Adopted by the American Federation of Teachers at its 1994 National Convention in Anaheim, California

FNHP Policy Statement on Safe Delegation

Your professional judgment is tested routinely in the course of every working day. Yet, when it comes to delegation of duty, the combination of high acuity and low staffing patterns place a strain on even the most experienced professional's judgment. Remember, you are "on the line" when you decide to delegate authority. While you may delegate authority, you cannot delegate responsibility.

Before you delegate, be sure that you are familiar with your state's Nurse Practice Act and any institutional policies regarding delegation at your place of employment. In some states, the Nurse Practice Act does not allow a registered nurse to delegate professional tasks regardless of the education or experience of the licensed practical nurse or nursing assistant to whom the tasks can be delegated. On the other hand, some institutions attempt to circumvent the nurse and inappropriately assign tasks to institutionally trained personnel.

When delegating, you need to ensure that the person to whom you are transferring your duties not only has the capacity to do the work but is also proficient at it. You, as the professional responsible for the care of your patients, have the final word in determining to whom you will delegate nursing tasks. No one else can make that determination.

Four factors to consider when delegating authority:

■ *EVALUATE*

—the patient's status and needs before determining whether tasks related to care can safely be delegated;

—the staff with whom you are working. Assign duties to licensed personnel before considering others; and

—the training and general competence of the person to whom you would delegate.

■ *EDUCATE*

—your patient about the fact that some care will be administered by a co-worker in whom you have confidence and whose work you will supervise;

—the person you've chosen about your patient's needs, treatment and care program and explain and demonstrate procedures; and

—your designee about expected outcomes. Also, talk about what circumstances would require your additional help.

■ *COMMUNICATE*

—confidence in the person you've chosen to perform the nursing task(s);

—expectations for performance and limits on intervention; and

—your receptiveness to discuss any concern, questions or hesitancy about performance of the task.

■ *SUPERVISE*

—*directly* any co-worker whose skill level you have concerns about, or who is performing the task for the first time. (Be sure to document everything.)

—*periodically* to re-evaluate skills and ensure excellence. But, first and foremost, *BE AVAILABLE.*

Adopted by the Program and Policy Council of the Federation of Nurses and Health Professionals, AFT, AFL-CIO, May 1992. Rev. January, 1997.

Appendix B

Position Papers from Non-AFT Organizations

1. NASN: Delegation Position Statement.

2. NASN: Delegation of Care.

3. NASN: Do Not Resuscitate Position Statement.

4. NCSB: Delegation: Concepts and Decision-Making Process.

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DELEGATION

POSITION STATEMENT

HISTORY:

The role of the school health nurse is expanding and becoming more complex.

DESCRIPTION OF ISSUE:

Students require nursing intervention for a wide variety of health-related problems. School health nurses often have responsibility for the health of students in more than one school site.

RATIONALE:

The definition of nursing practice for the school health nurse is based on The Nurse Practice Act, other laws in the jurisdiction in which the nurse is practicing, and School Nursing Practice: Roles and Standards, (NASN, 1993). The licensed professional school health nurse must use nursing assessment and professional judgment in deciding which procedures in the school setting may be delegated. In determining when to delegate nursing practice, a case management plan and/or an Individualized Health Care Plan needs to be developed.

CONCLUSION:

The National Association of School Nurses endorses and supports the position paper of the National Association of State School Nurse Consultants on Delegation of School Health Services to Unlicensed Assistive Personnel (1995) and the American Nurses' Association Position Statement on Registered Nurse Utilization of Unlicensed Assistive Personnel (1994) adapted (with permission) to the school community. The school health nurse should be involved in the development of school district policy and procedure related to the delegation of care. It is also recommended that school districts establish maximum allowable student-to-nurse ratios, taking into consideration students' health needs.

Issue Brief

School Health
Nursing Services
Role In Health Care

DELEGATION OF CARE

The National Association of School Nurses believes that every student has the right to receive health care that is planned, provided, and/or supervised by a registered school health nurse. Fundamental to this process is the presence of an adequate number of school health nurses. The school health nurse has sole responsibility and authority within the educational setting to delegate nursing services that promote the health and safety of school-age children.

"Delegation is the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome" (ANA, 1992). Nursing tasks and nursing procedures may be delegated solely by the supervising school health nurse based upon professional judgment; however, the professional nursing judgments of Assessment, Evaluation, and Care Planning may not be delegated.

The school health nurse is a licensed registered nurse whose ability to delegate is governed by laws, statutes and regulations found in the state nurse practice act and other laws within the practice jurisdiction. Decisions are guided by:

- School Nursing Practice: Roles and Standards (NASN, 1993)
- NASN position statement regarding delegation (NASN, 1994)
- ANA and NASN Code of Ethics
- State school nurse certification

Delegation of nursing services by a non-nurse and/or performance of nursing services without nurse supervision may constitute the practice of nursing without a license (NCSBN, 1990). The right to delegate nursing tasks, when not granted by the state nurse practice act, requires statutory authorization.

Primary consideration in the delegation of care is the health, safety and welfare of the school-age child. The school health nurse' s judgment regarding delegation is based upon assessment of:

- health care needs of the individual student
- health care needs of the school population
- nature, frequency and complexity of the specific task
- physician orders
- availability of adequate supervision
- education, training and skills of the unlicensed assistive personnel

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The school health nurse safeguards the student's well-being by assuring the unlicensed assistive personnel will receive adequate training and will provide care under on-going supervision and evaluation. Minimal training and education include nursing instruction with demonstration of the specific task, followed by the return task demonstration by the unlicensed assistive personnel in the educational setting under direct nursing supervision and evaluation.

Supervision is the active process of directing, guiding and influencing the outcome of an individual's performance of an activity. Supervision is generally categorized as *on-site* (the school health nurse is physically present and immediately available while the task is performed) or *off-site* (the school health nurse has the ability to provide direction through various means of written and verbal communication) (ANA, 1992). The relationship between delegation and supervision legally and administratively requires that appropriate supervision be available during task implementation.

School policy regarding delegation should be promulgated. The procedural guidelines are written, recorded, accessible to all and indicate:

- extent and type of supervision required
- safety and emergency guidelines
- development of an individualized health care plan for each student
- documentation requirements

The authority and responsibility of the school health nurse to delegate can offer a means for expanded services in the delivery of health services in the educational setting.

REFERENCES

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DO NOT RESUSCITATE

POSITION STATEMENT

HISTORY:

Increased numbers of medically fragile, chronically ill students are in school.

DESCRIPTION OF ISSUE:

In some instances, parents of chronically ill students do not wish CPR to be initiated in the case of respiratory or cardiac arrest. The school district may be petitioned to honor a DO NOT RESUSCITATE order.

RATIONALE:

DO NOT RESUSCITATE orders are a sensitive issue. School health nurses will often need assistance in developing a plan of care for medically fragile students when it is possible to honor a DNR order.

CONCLUSION:

It is the position of the National Association of School Nurses that DO NOT RESUSCITATE orders for medically fragile students must be evaluated on an individual basis at the local level, according to state and local laws. The local Board of Education should refer this matter to school district legal counsel for guidance. Each student involved should have an Individualized Health Care Plan developed by the professional school health nurse with involvement from the parents, administrator, physician, teacher, and student, when appropriate. It needs to include a written DNR request from the parent(s) as well as the physician's written DNR order. The plan should be reviewed at least annually. The health plan also should state the steps to be taken in case of respiratory or cardiac arrest.

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Delegation: CONCEPTS AND DECISION-MAKING PROCESS

INTRODUCTION

To meet the public's increasing need for accessible, affordable, quality health care, providers of health care must maximize the utilization of every health care worker and ensure appropriate delegation of responsibilities and tasks. Nurses, who are uniquely qualified for promoting the health of the whole person by virtue of their education and experience, must be actively involved in making health care policies and decisions; they must coordinate and supervise the delivery of nursing care, including the delegation of nursing tasks to others.

Issues related to delegation have become more complex in today's evolving health care environment, creating a need for practical guidelines to direct the process for making delegatory decisions. Accordingly, this paper expands and builds upon the National Council's 1987 and 1990 conceptual and historical papers on delegation by presenting a dynamic decision-making process and practical guidelines for delegation.

PURPOSE

The purpose of this paper is to provide a resource for Boards of Nursing, health policy makers, and health care providers on delegation and the roles of licensed and unlicensed health care workers. The paper emphasizes and clarifies the responsibility of Boards of Nursing for the regulation of nursing, including nursing tasks performed by unlicensed health care workers, and the responsibility of licensed nurses to delegate nursing tasks in accord with their legal scopes of practice. It provides a decision-making tool which can be used in clinical and administrative settings to guide the process of delegation. This paper also describes the accountability of each person involved in the delegation process and potential liability if competent, safe care is not provided.

PREMISES

The following premises constitute the basis for the delegation decision-making process.

1. All decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety and welfare of the public.
2. Boards of Nursing are responsible for the regulation of nursing. Provision of any care which constitutes nursing or any activity represented as nursing is a regulatory responsibility of Boards of Nursing.
3. Boards of Nursing should articulate clear principles for delegation, augmented by clearly defined guidelines for delegation decisions.

4. A licensed nurse must have ultimate responsibility and accountability for the management and provision of nursing care.
5. A licensed nurse must be actively involved in and be accountable for all managerial decisions, policy making and practices related to the delegation of nursing care.
6. There is a need and a place for competent, appropriately supervised, unlicensed assistive personnel in the delivery of affordable, quality health care. However, it must be remembered that unlicensed assistive personnel are equipped to assist—not replace—the nurse.
7. Nursing is a knowledge-based process discipline and cannot be reduced solely to a list of tasks. The licensed nurse's specialized education, professional judgment and discretion are essential for quality nursing care.
8. While nursing tasks may be delegated, the licensed nurse's generalist knowledge of patient care indicates that the practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated.
9. A task delegated to an unlicensed assistive person cannot be redelegated by the unlicensed assistive person.
10. Consumers have a right to health care that meets legal standards of care. Thus, when a nursing task is delegated, the task must be performed in accord with established standards of practice, policies and procedures.
11. The licensed nurse determines and is accountable for the appropriateness of delegated nursing tasks. Inappropriate delegation by the nurse and/or unauthorized performance of nursing tasks by unlicensed assistive personnel may lead to legal action against the licensed nurse and/or unlicensed assistive personnel.

DEFINITIONS

Accountability	Being responsible and answerable for actions or inactions of self or others in the context of delegation.
Delegation	Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.
Delegator	The person making the delegation.
Delegatee	The person receiving the delegation. (a.k.a. Delegate)
Supervision	The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.
Unlicensed Assistive Personnel (UAP)	Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.

REGULATORY PERSPECTIVE: A FRAMEWORK FOR MANAGERIAL POLICIES

Boards of Nursing have the legal responsibility to regulate nursing and provide guidance regarding delegation. Registered Nurses (RNs) may delegate certain nursing tasks to Licensed Practical Nurses/Vocational Nurses (LPN/VNs) and unlicensed assistive personnel (UAP). In some jurisdictions, LPN/VNs may also delegate certain tasks within their scope of practice to unlicensed assistive personnel. The licensed nurse has a responsibility to assure that the delegated task is performed in accord with established standards of practice, policies and procedures. The nurse who delegates retains accountability for the task delegated.

The regulatory system serves as a framework for managerial policies related to the employment and utilization of licensed nurses and unlicensed assistive personnel. The nurse who assesses the patient's needs and plans nursing care should determine the tasks to be delegated and is accountable for that delegation. It is inappropriate for employers or others to require nurses to delegate when, in the nurse's professional judgment, delegation is unsafe and not in the patient's best interest. In those instances, the nurse should act as the patient's advocate and take appropriate action to ensure provision of safe nursing care. If the nurse determines that delegation may not appropriately take place, but nevertheless delegates as directed, the nurse may be disciplined by the Board of Nursing.

Acceptable Use of the Authority to Delegate

The delegating nurse is responsible for an individualized assessment of the patient and situational circumstances, and for ascertaining the competence of the delegatee before delegating any task. The practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated. Supervision, monitoring, evaluation and follow-up by the nurse are crucial components of delegation. The delegatee is accountable for accepting the delegation and for his/her own actions in carrying out the task.

The decision to delegate should be consistent with the nursing process (appropriate assessment, planning, implementation and evaluation). This necessarily precludes a list of nursing tasks that can be routinely and uniformly delegated for all patients in all situations. Rather, the nursing process and decision to delegate must be based on careful analysis of the patient's needs and circumstances. Also critical to delegation decisions are the qualifications of the proposed delegatee, the nature of the nurse's delegation authority set forth in the law of the jurisdiction, and the nurse's personal competence in the area of nursing relevant to the task to be delegated.

Delegation Decision-Making Process

In delegating, the nurse must ensure appropriate assessment, planning, implementation and evaluation. The delegation decision-making process, which is continuous, is described by the following model:

I. Delegation criteria
   A. Nursing Practice Act
      1. Permits delegation
      2. Authorizes task(s) to be delegated or authorizes the nurse to decide delegation
   B. Delegator qualifications
      1. Within scope of authority to delegate
      2. Appropriate education, skills and experience
      3. Documented/demonstrated evidence of current competency
   C. Delegatee qualifications
      1. Appropriate education, training, skills and experience
      2. Documented/demonstrated evidence of current competency

Provided that this foundation is in place, the licensed nurse may enter the continuous process of delegation decision-making.

II. Assess the situation
   A. Identify the needs of the patient, consulting the plan of care
   B. Consider the circumstances/setting
   C. Assure the availability of adequate resources, including supervision

If patient needs, circumstances, and available resources (including supervisor and delegatee) indicate patient safety will be maintained with delegated care, proceed to III.

III. Plan for the specific task(s) to be delegated
   A. Specify the nature of each task and the knowledge and skills required to perform it
   B. Require documentation or demonstration of current competence by the delegatee for each task
   C. Determine the implications for the patient, other patients, and significant others

If the nature of the task, competence of the delegatee, and patient implications indicate patient safety will be maintained with delegated care, proceed to IV.

IV. Assure appropriate accountability
  A. As delegator, accept accountability for performance of the task(s)
  B. Verify that delegatee accepts the delegation and the accountability for carrying out the task correctly

If delegator and delegatee accept the accountability for their respective roles in the delegated patient care, proceed to V.

V. Supervise performance of the task
  A. Provide directions and clear expectations of how the task(s) is to be performed
  B. Monitor performance of the task(s) to assure compliance to established standards of practice, policies and procedures
  C. Intervene if necessary
  D. Ensure appropriate documentation of the task(s)

VI. Evaluate the entire delegation process
  A. Evaluate the patient
  B. Evaluate the performance of the task(s)
  C. Obtain and provide feedback

VII. Reassess and adjust the overall plan of care as needed

The Five Rights of Delegation provide an additional resource to facilitate decisions about delegation.

THE FIVE RIGHTS OF DELEGATION

- **RIGHT TASK**
  One that is delegable for a specific patient.

- **RIGHT CIRCUMSTANCES**
  Appropriate patient setting, available resources, and other relevant factors considered.

- **RIGHT PERSON**
  Right person is delegating the right task to the right person to be performed on the right person.

- **RIGHT DIRECTION/COMMUNICATION**
  Clear, concise description of the task, including its objective, limits and expectations.

- **RIGHT SUPERVISION**
  Appropriate monitoring, evaluation, intervention, as needed, and feedback.

CONCLUSION

The guidelines presented in this paper provide a decision-making process that facilitates the provision of quality care by appropriate persons in all health care settings. The National Council of State Boards of Nursing believes that this paper will assist all health care providers and health care facilities in discharging their shared responsibility to provide optimum health care that protects the public's health, safety and welfare.

Appendix C
Sample State Legislation

1. Louisiana: Catheterization

2. Louisiana: Non-Complex Medical Intervention

Louisiana Legislation

Catheterization

Regular Session, 1990

HOUSE BILL NO. 886

BY REPRESENTATIVE GARRITY AND SENATOR BAGNERIS

AN ACT

To enact R.S. 17:435, relative to administering of catheters to students by school board employees, to provide certain required conditions and restrictions, to provide with respect to the authority of school boards to require employees other than registered nurses or licensed medical physicians to perform catheterizations, and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1 R.S. 17:435 is hereby enacted to read as follows: Administering catheters, conditions, restrictions

A. No city or parish school board shall require any employee other than a registered nurse or licensed medical physician to catheterize any student until all of the following conditions have been met:

(1) A registered nurse or licensed medical physician, employed by a city or parish school board, has assessed the health status of the specific child in his specific educational setting. The registered nurse has determined that according to the Louisiana Legal Standards of Nursing Practice the procedure could be safely performed, the results are predictable and could be delegated to someone other than a registered nurse following documented training.

(2) The registered nurse or licensed medical physician shall train at least two employees to catheterize the specific child in his educational setting. The employees shall be given not less than eight hours of training in the area of catheterization of students.

(3) Following the training provided for in paragraph (2), no catheterization may be performed unless prescribed in writing by a licensed medical physician. The employee, other than the registered nurse or licensed medical physician, shall be required to complete, under the direct supervision of a registered nurse, a minimum of five catheterizations. Upon one hundred percent successful completion of these catheterizations, the registered nurse or licensed medical physician and the trainee shall sign a standard form indicating that the trainee has attained the prescribed level of competency. A copy of this form shall be kept on file by the school system.

(4) Individuals who are required to perform catheterizations and have been trained according to the provisions of this Section, may not decline to perform such service except as exempted by a licensed medical physician or a registered nurse. The reasons for such exemption shall be documented and certified by the licensed medical physician or a registered nurse within seventy-two hours.

(5) Any employee shall have the right to request that another school board employee be present while

catheterizing the student, to serve as a witness to the procedure. After making such a request, the employee shall not be required to catheterize a student without such a witness.

B. The provisions of this Section shall be restricted to those students who have had intermittent catheterization prescribed as a treatment for urinary or neuralgic dysfunction and not for continuous bladder drainage or to obtain urine specimens for diagnostic purposes. No employee shall be requested to catheterize any student for continuous bladder drainage or to obtain urine specimens for diagnostic purposes.

Section 2. This act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided in Article III, Section 18 of the Constitution of Louisiana.

Non-Complex Medical Intervention

To enact relative to performing non-complex medical interventions (Activities of Daily Living, Respiratory Assistance, Screenings) on students by school board employees, to provide certain required conditions and restrictions, to provide with respect to the authority of school boards to require employees other than registered nurses or licensed medical physicians to perform non-complex interventions, and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Performing non-complex medical interventions: conditions, restrictions:

A. No city or parish school board shall require any employee other than a registered nurse or licensed medical physician to perform non-complex medical interventions until all the following conditions have been met:

(1) To define a non-complex intervention task, it is one which can be safely performed according to exact directions, with no need to alter the standard procedure, and the results are predictable.

(a) Activities of Daily Living will include the following: toileting/diapering, bowel/bladder training, toilet training, oral/dental hygiene, lifting/positioning, oral feeding, gastrectomy feeding and monitoring.

(b) Respiratory Assistance will include the following: postural drainage, percussion, suctioning and oral pharyngeal.

(c) Screenings will include the following: growth, vital signs, hearing, vision and scoliosis.

(2) A registered nurse or licensed medical physician, employed by a city or parish school board, has assessed the health status of the specific child in his specific educational setting. The registered nurse has determined that according to the Louisiana Legal Standards of Nursing Practice the procedure could be safely performed, the results are predictable and could be delegated to someone other than a registered nurse following documented training.

(3) The registered nurse or licensed medical physician shall train at least two employees to perform non-complex medical interventions on the specific child in his educational setting. The employees shall be given not less than four hours of training in the area of non-complex medical interventions.

(4) Following the training provided for in paragraph (3) no non-complex medical intervention, except screenings, may be performed unless prescribed in writing by a physician licensed to practice in the state of Louisiana. The employee, other than the registered nurse or licensed medical physician, shall be required to complete, under the direct supervision of a registered nurse, a minimum of three (3) satisfactory demonstrations. Upon satisfactory completion of these non-complex medical interventions, the registered nurse or licensed medical physician and the trainee shall sign a standard form indicating that the trainee has attained the prescribed level of competency. A copy of this form shall be kept on file by the school system.

(5) Individuals who are required to perform non-complex medical interventions and have been trained according to the provisions of this Section, may not decline to perform such service at the time indicated except as exempted for reasons as noted by the licensed medical physician or registered nurse. The reasons for such exemption shall be documented and certified by the licensed medical physician or a registered nurse within seventy-two hours.

(6) Any employee shall have the right to request that another school board employee be present while performing non-complex medical interventions on the student. That employee shall serve as a witness to the procedure. After making such a request, the employee shall not be required to perform non-complex medical interventions without such a witness.

Section 1. This action shall become effective upon signature by the governor or if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided in Article III, Section 18 of the Constitution of Louisiana.

Appendix D

Guidance for Staff Roles in Providing Care

1. New York State Department of Education: Guidelines on Health-Related Activities

2. AFT / CEC / NASN / NEA: Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting

New York State Department of Education Guidelines on Health Related Activities

*Nursing activities that may be performed by registered professional nurses or licensed practical nurses under the direction of a registered nurse and may not be performed by unlicensed persons.**

- Observations and data collection
- Administration of subcutaneous, intramuscular, intravenous, or rectal medications
- Administering oral, topical,and inhalant medication to non-self-directed students according to State Education Department Guidelines
- Problem assessment/intervention-insulin pump
- Gastrostomy feeding (bolus method or with medication)
- Initiation of gastrostomy feeding by drip method (monitoring of the drip feeding can be assigned after initiation by the licensed nurse)
- Nasogastric tube feedings
- Oxygen administration (pm/intermittent) or initiation of continuous oxygen
- Nebulizer with oxygen or medication
- Oropharyngeal suctioning
- Tracheostomy suctioning
- Tracheostomy care
- Respirator/ventilator care
- Respiratory care (postural drainage and cupping, etc.)

- Urinary catheterization
- Reinsertion of an indwelling urinary catheter
- Ostomy care (care of stoma and changing the appliance)
- Cast care
- Warm applications
- Sterile dressings
- Decubitus ulcer care
- Blood glucose monitoring
- Intake and output measurements of gastric and parenteral fluids
- Monitoring of shunt function

*Health related activities that may be performed by appropriately trained unlicensed persons following assessment and approval by a registered nurse**

- Measurement and recording of vital signs that can be performed according to standard procedures
- Application of clean dressings when no assessment is necessary
- Ostomy care (emptying bag and observing the integrity of the bag for possible replacement by a licensed nurse)
- Observation to ensure continuous flow of an established drip method gastrostomy feeding that has been initiated by the nurse
- Termination of a drip method gastrostomy feeding after completion of the feeding if flushing is not involved
- Intake and output measurement and recording (except gastric and parenteral fluids)
- Assisting self-directed students with own oral, topical, and inhalant medication according to State Education Department guidelines
- Observing that equipment used to administer continuous flow oxygen is working and that all tubes are in place
- Oral suctioning (mouth only, not pharynx)
- External catheter care
- External care of indwelling catheter
- Nebulizer treatment, if routine and without medication or oxygen
- Transfers
- Aspects of a prescribed exercise and/or range of motion program
- Assistance with braces and prostheses
- Assisted ambulation (crutches, walker, cane)
- Positioning

*Health-related activities that may, under most circumstances, be performed by unlicensed persons without the involvement of a registered professional nurse**

- Oral hygiene or nail, hair, and skin care
- Preparing nourishment
- Feeding student orally as long as there are no feeding problems
- Care of an incontinent student
- Assistance with bedpan and urinal
- Non-medical aspects of bowel and bladder training
- Assistance with clothing

**These activities are illustrative only. These lists are not all inclusive.*

Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting

Developed by

The Joint Task Force for the Management of
Children with Special Health Needs of the:

American Federation of Teachers (AFT)

The Council for Exceptional Children (CEC)

National Association of School Nurses, Inc. (NASN)

National Education Association (NEA)

May 1, 1990

Matrix of Professional Responsibilities for the Delivery of Special Health Care Procedures in Educational Settings

The following matrix lists 66 special health care procedures that some children may need to have provided in educational settings. The procedures vary in the degree to which they require specialized knowledge and skill by persons conducting the procedure. Many are regulated by professional standards of practice. This matrix delineates the persons who are qualified to perform each of the procedures, who should preferably perform the procedures, and the circumstances under which these persons would be deemed qualified. It should be noted that the term qualified assumes that the individual has received appropriate training in the procedures.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESS-IONALS[2]	OTHERS[3]
1.0 ACTIVITIES OF DAILY LIVING							
1.1 Toileting/Diapering		A	A	A	A	(A)	A
1.2 Bowel/Bladder Training (Toilet Training)		A	A	(A)	A	S	S
1.3 Dental Hygiene		A	A	A	A	S	S
1.4 Oral Hygiene		A	A	(A)	A	S	S
1.5 Lifting/Positioning		A	A	(A)	A	S	S
1.6 Feeding							
1.6.1 Nutrition Assessment		A	X	X	N	X	X
1.6.2 Oral-Motor Assessment		X	X	X	(SP/TH)	X	X
1.6.3 Oral Feeding		A	A	A	A	(S)	S
1.6.4 Naso-Gastric Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.5 Monitoring of Naso-Gastric Feeding		A	S	S	S	S	X
1.6.6 Gastrostomy Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.7 Monitoring of Gastrostomy Feeding		A	S	S	S	S	X
1.6.8 Jejunostomy Tube Feeding	*	(A)	(S)	X	X	X	X
1.6.9 Total Parenteral Feeding (Intravenous)	*	(A)	(S)	X	X	X	X
1.6.10 Monitoring of Parenteral Feeding		A	S	S	S	S	X

DEFINITION OF SYMBOLS

A Qualified to perform task, not in conflict with professional standards
S Qualified to perform task with RN supervision and inservice education
EM In emergencies, if properly trained, and if designated professional is not available
X Should not perform

N Nutritionist only
TH Occupational or physical therapist only
SP Speech/language Pathologist only
○ Person who should be designated to perform task

HA Health Aide only

---

1 Related Services include N, TH, and SP.

2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.

3 Others include secretaries, bus drivers, cafeteria workers, custodians.

*** DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.**

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE		PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESS-IONALS[2]	OTHERS[3]
1.6.11	Naso-Gastric Tube Insertion	*	(A)	(S)	X	X	X	X
1.6.12	Naso-Gastric Tube Removal	*	(A)	(S)	EM	EM	EM/HA	X
1.6.13	Gastrostomy Tube Reinsertion	*	(A)	(S)	X	X	X	X
2.0	**CATHETERIZATION**							
2.1	Clean Intermittent Catheterization	*	(A)	(S)	X	X	S/HA	X
2.2	Sterile Catheterization	*	(A)	(S)	X	X	X	X
2.3	Crede	*	A	S	S	S	(S/HA)	S
2.4	External Catheter	*	(A)	(A)	S	S	(S/HA)	X
2.5	Care of Indwelling Catheter (Not Irrigation)	*	(A)	(S)	S	S	(S/HA)	X
3.0	**MEDICAL SUPPORT SYSTEMS**							
3.1	Ventricular Peritoneal Shunt							
3.1.1	Pumping	*	(EM)	(EM)	X	X	X	X
3.1.2	Monitoring	*	(A)	S	S	S	S	X
3.2	Mechanical Ventilator							
3.2.1	Monitoring	*	(A)	(S)	EM	EM	S/HA	X
3.2.2	Adjustment of Ventilator	*	X	X	X	X	X	X
3.2.3	Equipment Failure	*	(A)	(S)	EM	EM	EM	EM

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○ Person who should be designated to perform task
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PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
3.3 Oxygen							
3.3.1 Intermittent	*	Ⓐ	Ⓢ	EM	EM	EM	X
3.3.2 Continuous (Monitoring)	*	A	S	S	S	S	S
3.4 Hickman/Broviac/IVAC/IMED	*	Ⓐ	Ⓢ	X	X	X	X
3.5 Peritoneal Dialysis	*	Ⓐ	Ⓢ	X	X	X	X
3.6 Apnea Monitor	*	A	S	S	S	S/HA	X

4.0 MEDICATIONS

Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
4.1 Oral	*	Ⓐ	Ⓢ	X	X	S/HA	X
4.2 Injection	*	Ⓐ	Ⓢ	X	X	X	X
4.3 Epi-Pen Allergy Kit	*	Ⓐ	Ⓢ	EM	EM	EM	EM
4.4 Inhalation	*	Ⓐ	Ⓢ	EM	EM	EM/HA	EM
4.5 Rectal	*	Ⓐ	Ⓢ	X	X	EM/HA	X
4.6 Bladder Installation	*	Ⓐ	Ⓢ	X	X	X	X
4.7 Eye/Ear Drops	*	Ⓐ	Ⓢ	X	X	S/HA	X

DEFINITION OF SYMBOLS

A	Qualified to perform task, not in conflict with professional standards	N	Nutritionist only	HA	Health Aide only
S	Qualified to perform task with RN supervision and inservice education	TH	Occupational or physical therapist only		
EM	In emergencies, if properly trained, and if designated professional is not available	SP	Speech/language Pathologist only		
X	Should not perform	○	Person who should be designated to perform task		

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GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE		PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESSIONALS[2]	OTHERS[3]
4.8	Topical	*	Ⓐ	Ⓢ	X	X	S/HA	X
4.9	Per Nasogastric Tube	*	Ⓐ	Ⓢ	X	X	S/HA	X
4.10	Per Gastrostomy Tube	*	Ⓐ	Ⓢ	X	X	S/HA	X
4.11	Intravenous	*	Ⓐ	Ⓢ	X	X	X	X
4.12	Spirometer	*	Ⓐ	Ⓢ	X	X	S/HA	X
5.0	**OSTOMIES**							
5.1	Ostomy Care	*	Ⓐ	Ⓢ	EM	EM	EM	X
5.2	Ostomy Irrigation	*	Ⓐ	Ⓢ	X	X	X	X
6.0	**RESPIRATORY ASSISTANCE**							
6.1	Postural Drainage	*	Ⓐ	Ⓢ	S	S	S/HA	S
6.2	Percussion	*	Ⓐ	Ⓢ	S	TH	S/HA	S
6.3	Suctioning							
6.3.1	Pharyngeal	*	Ⓐ	Ⓢ	S	S	S/HA	X
6.3.2	Tracheostomy	*	Ⓐ	Ⓢ	S	S	S/HA	X
6.4	Tracheostomy Tube Replacement	*	(EM)	(EM)	EM	EM	EM	EM
6.5	Tracheostomy Care (Cleaning)	*	Ⓐ	Ⓢ	X	X	X	X

DEFINITION OF SYMBOLS

A	Qualified to perform task, not in conflict with professional standards	N	Nutritionist only	HA	Health Aide only
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EM	In emergencies, if properly trained, and if designated professional is not available	SP	Speech/language Pathologist only		
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GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE		PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESS-IONALS[2]	OTHERS[3]
7.0	**SCREENINGS**							
7.1	Growth		Ⓐ	Ⓢ	S	S	S	X
7.2	Vital Signs		Ⓐ	Ⓢ	X	X	S/HA	X
7.3	Hearing		Ⓐ	Ⓢ	X	(SP)	S/HA	X
7.4	Vision		Ⓐ	Ⓢ	X	X	S/HA	X
7.5	Scoliosis		Ⓐ	Ⓢ	S	TH	S/HA	X
8.0	**SPECIMEN COLLECTING/TESTING**							
8.1	Blood Glucose	*	Ⓐ	Ⓢ	X	X	S/HA	X
8.2	Urine Glucose	*	Ⓐ	Ⓢ	X	X	S/HA	X
9.0	**OTHER HEALTH CARE PROCEDURES**							
9.1	Seizure Procedures		A	A	A	A	A	A
9.2	Soaks	*	Ⓐ	Ⓢ	X	TH	S/HA	X
9.3	Dressings, Sterile	*	Ⓐ	S	X	X	X	X

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PROCEDURE		PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL[1]	PARA PROFESS-IONALS[2]	OTHERS[3]
10.0	**DEVELOPMENT OF PROTOCOLS**							
10.1	Health Care Procedures		Ⓐ	X	X	X	X	X
10.2	Emergency Protocols	*	Ⓐ	(WITH PHYSICIAN CONSULTATION)				
10.3	Individual Education Plan Health Objectives		Ⓐ	X	X	X	X	X
10.4	Nursing Care Plan		Ⓐ	X	X	X	X	X

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Appendix E

Summary of State Nurse Practice Act Provisions

(Many professional nurses delegate to or supervise unlicensed personnel in a classroom or public setting.)

STATE	*RESPONSE*
Alabama	Teaching only, no delegation or supervision.
Alaska	"Allows for supervision, delegation, and evaluation of nursing practice."
Arizona	Delegation and supervision to auxiliary workers within the scope of their practice, e.g., nurse aides. Medications in schools through school personnel under study.
Arkansas	Supervision and teaching of other personnel. Limited delegation according to regulations. Some tasks can be delegated.
California	School nurse may supervise "qualified, designated" school personnel to give physical care to student. Care must be under school nurse.
Colorado	Delegation and supervision to unlicensed personnel permitted.
Connecticut	RNs can delegate to LPNs. They can delegate to unlicensed assistive personnel things that do not require nursing judgement as long as the delegates have 2 levels of state-specified training.
D.C.	By attorney opinion, allows for delegation and supervision.
Delaware	Permits delegation, supervision, and teaching. RNs only. Board has defined exceptions to delegation.
Florida	Delegation and supervision are not in the statute, but regulations define what may not be delegated.
Georgia	"May teach and supervise." The term "delegation" is not included in broad practice standard to delegate and supervise under appropriate conditions. Teaching and supervision are discussed, but there is no mention of delegation.
Hawaii	May teach and supervise and delegate portions of nursing practice, but if any are improperly performed the nurse is subject to "professional misconduct."
Idaho	Position Statement on Role and Responsibility of School Nurse allows delegation and teaching if there is no conflict within the Practice Act. School nurses can delegate to anyone, including teachers.
Illinois	Delegation is permitted under the defined rules of the Practice Act.
Indiana	RN can delegate and supervise only. Nurses may delegate to licensed personnel only.
Iowa	"Position Statement" and Act allow for teaching and supervision, but no delegation.
Kansas	Delegation in school setting of specific tasks. Under review.
Kentucky	Regulations permit delegation. Supervision, delegation, and teaching in statute definition. There are parameters for delegation to unlicensed personnel.
Louisiana	Allows for instruction, supervision and delegation based on delegation criteria not tasks.
Maine	Delegation to LPNs and nursing assistants. Teaching permitted.
Maryland	Awaiting revision. Delegation and supervision by declamatory ruling.
Massachusetts	Teaching, delegation, and supervision (of unlicensed personnel) are permitted.

Michigan	Permits delegation, teaching, and supervision by registered nurses.
Minnesota	May be delegated to nursing personnel (broadly defined).
Mississippi	Delegation allowed within professional judgment of nurse. Teaching, delegation, and supervision in definition.
Missouri	Teaching and supervision of unlicensed individuals, but no delegation of tasks.
Montana	Teaching, supervision, and delegation are permitted.
Nebraska	Permits delegation, teaching; supervision implied.
Nevada	Teaching, supervision, and delegation are permitted.
New Hampshire	Allows "teaching, direction and delegation."
New Jersey	No delegation or supervision and teaching of persons by statute.
New Mexico	By declaratory ruling: May delegate to non-licensed person who is prepared by education and experience to recognize and handle complications that may arise. Statute permits teaching and supervision, but does not mention delegation.
New York	RNs can delegate to LPNs.
North Carolina	May delegate to unlicensed person if six criteria are met (administrative rule). Includes "personal care" in a school setting. Supervision and teaching only contained in Act itself.
North Dakota	Teaching, supervision, and delegation are permitted. Delegation is permitted only to licensed personnel. Task Force is discussing this issue.
Ohio	May supervise and delegate nursing practice.
Oklahoma	Delegation, supervision, and teaching allowed.
Oregon	Declaratory ruling regarding unauthorized practice by school aides allowing CIC. Teaching and delegation permitted; supervision of "nursing assistants" allowed.
Pennsylvania	Health teaching permitted. No mention of delegation or supervision in Act itself.
Rhode Island	Teaching and delegation are permitted but no supervision. Delegation is permitted only to licensed personnel.
South Carolina	Delegation and supervision of routine nursing tasks allowed by interpretation (not meds). Teaching, supervision, and delegation are permitted.
South Dakota	Scope of practice permits teaching, delegation, and supervision. However, aiding or abetting "an unlicensed or uncertified person to practice nursing" is grounds for relocation or suspension of nursing license.
Tennessee	"May manage, supervise and teach. . . ." Defines "adequate supervision" and places within judgment of nurse. Teaching, delegation, and supervision are permitted.
Texas	May supervise and delegate. Texas Education Code gives immunity to school personnel administering medications.
Utah	Limited delegation in accordance with guidelines from Practice Issues Committee regarding child with Special Health Care Needs in School Setting. Teaching, delegation, and supervision are permitted by Act.
Vermont	Delegation and supervision are permitted.
Virginia	Nurse may supervise and teach, but no delegation permitted. Legislative amendment likely.
Washington	Delegation, supervision, and teaching are permitted.
West Virginia	Supervision, teaching and delegation permitted. Delegation permitted to other nurses only.
Wisconsin	Delegation and supervision allowed. Under study by task force.
Wyoming	Teaching, supervision, and delegation are permitted.

More specific information is available from the AFT and your state's Board of Nursing.

Original study/survey conducted in 1991 by: Peg Long, J.D., Colorado, and Susan Smith, R.N., J.D., Colorado.

Updates made by AFT in 1993 and 1996.

Appendix F
Directory of State Boards of Nursing

ALABAMA

Alabama Board of Nursing
PO Box 303900
Montgomery, AL 36130-3900
Phone: (205) 242-4060
Fax: (205) 242-4360

ALASKA

Alaska Board of Nursing
Department of Commerce and Economic Development
Div. of Occupational Licensing
3601 C Street, Suite 722
Anchorage, AK 99503
Phone: (907) 561-2878
Fax: (907) 562-5781

AMERICAN SAMOA

American Samoa Health Service Regulatory Board
LBJ Tropical Medical Center
Pago Pago, American Samoa 99503
Phone: (684) 633-1222 ext. 206
Fax: 011-684-633-1869

ARIZONA

Arizona State Board of Nursing
1651 E. Morten Ave., Suite 150
Phoenix, AZ 85020
Phone: (602) 255-5092
Fax: (602) 255-5130

ARKANSAS

Arkansas State Board of Nursing
University Tower Building, Suite 800
1123 South University
Little Rock, AR 72204
Phone: (501) 686-2700
Fax: (501) 686-2714

CALIFORNIA—RNs

California Board of Registered Nursing
PO Box 944210
Sacramento, CA 94244-2100
Phone: (916) 322-3350
Fax: (916) 327-4402

CALIFORNIA—VN

California Board of Vocational Nurse and Psychiatric Technician Examiners
1414 K Street, Suite 103
Sacramento, CA 95814
Phone: (916) 445-0793
Fax: (916) 327-4408

COLORADO

Colorado Board of Nursing
1560 Broadway, Suite 670
Denver, CO 80202
Phone: (303) 894-2430
Fax: (303) 894-2821

CONNECTICUT

Connecticut Board of Examiners for Nursing
150 Washington Street
Hartford, CT 06106
Phone: (203) 566-1041
Fax: (203) 566-6606

DELAWARE

Delaware Board of Nursing
Margaret O'Neill Building
PO Box 1401
Dover, DE 19903
Phone: (302) 739-4522
Fax: (302) 739-2711

DISTRICT OF COLUMBIA

District of Columbia Board of Nursing
614 H Street N.W.
Washington, DC 20001
Phone: (202) 727-7468
Fax: (202) 727-2711

FLORIDA

Florida Board of Nursing
111 Coastline Drive East, Suite 516
Jacksonville, FL 32202
Phone: (904) 359-6331
Fax: (904) 359-6323

GEORGIA—LPNs

Georgia State Board of Licensed Practical Nursing
166 Pryor Street SW
Atlanta, GA 30303
Phone: (404) 656-3921
Fax: (404) 651-9532

GEORGIA—RNs

Georgia Board of Nursing
166 Pryor Street SW
Atlanta, GA 30303
Phone: (404) 656-3943
Fax: (404) 651-9532

GUAM

Guam Board of Nurse Examiners
PO Box 2816
Agana, Guam 96910
Phone: 011-671-734-7295 (6) or 011-671-734-7304
Fax: 011-671-743-2066

HAWAII

Hawaii Board of Nursing
PO Box 3469
Honolulu, HI 96801
Phone: (808) 586-2695
Fax: (808) 586-2689

IDAHO

Idaho Board of Nursing
280 N. 8th Street, Suite 210
Boise, ID 83270
Phone: (208) 334-3110
Fax: (208) 334-3262

ILLINOIS

Illinois Dept. of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, IL 62786

or

Illinois Dept. of Professional Regulation
100 West Randolph, Suite 8-300
Chicago, IL 60601
Phone: (217) 785-9465
(217) 785-0800
Fax: (217) 782-7645

or

Phone: (312) 814-5303
(312) 814-4543
Fax: (312) 814-3154

INDIANA

Indiana Board of Nursing
Health Professions Bureau
402 West Washington Street
Room #401
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

IOWA

Iowa Board of Nursing
State Capitol Complex
1223 East Court Avenue
Des Moines, IA 50319
Phone: (515) 281-3255
Fax: None

KANSAS

Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson, Suite 551-S
Topeka, KS 66612-1230
Phone: (913) 296-4929
Fax: (913) 296-3929

KENTUCKY

Kentucky Board of Nursing
312 Wittington Parkway, Suite 300
Louisville, KY 40222-5172
Phone: (502) 329-7000
Fax: (502) 329-7011

LOUISIANA—RNs

Louisiana State Board of Nursing
912 Pere Marquette Building
150 Barone Street
New Orleans, LA 70112
Phone: (504) 568-5464
Fax: (504) 568-5467

LOUISIANA—LPNs

Louisiana State Board of Practical Nurse Examiners
Tidewater Place
1440 Canal Street, Suite 1722
New Orleans, LA 70112
Phone: (504) 568-6480
Fax: (504) 568-6482

MAINE

Maine State Board of Nursing
State House Station #158
Augusta, ME 04333-0158
Phone: (207) 624-5275
Fax: (207) 624-5290

MARYLAND

Maryland Board of Nursing
4140 Patterson Avenue
Baltimore, MD 21215-2299
Phone: (410) 764-5124
Fax: (410) 358-3530

MASSACHUSETTS

Massachusetts Board of Registration in Nursing
Leverett Saltonstall Building
100 Cambridge Street, Room 1519
Boston, MA 02202
Phone: (617) 727-9962
Fax: (617) 727-2197

MICHIGAN

Bureau of Occupational and Professional Regulation
Michigan Department of Commerce
Ottawa Towers North
611 West Ottawa
Lansing, MI 48933
Phone: (517) 373-1600
Fax: (517) 373-2217

MINNESOTA

Minnesota Board of Nursing
2700 University Avenue, West #108
St. Paul, MN 55114
Phone: (612) 642-0567
Fax: (612) 642-0574

MISSISSIPPI

Mississippi Board of Nursing
239 N. Lamar Street, Suite 401
Jackson, MS 39201
Phone: (601) 359-6170
Fax: (601) 359-6185

MISSOURI

Missouri State Board of Nursing
PO Box 656
Jefferson City, MO 65102
Phone: (314) 751-0681
Fax: (314) 751-0075

MONTANA

Montana State Board of Nursing
Department of Commerce
Arcade Building, Lower Level
111 North Jackson
Helena, MT 59620-0407
Phone: (406) 444-4279
Fax: (406) 444-1667

NEBRASKA

Bureau of Examining Boards
Nebraska Department of Health
PO Box 95007
Lincoln, NE 68509
Phone: (402) 471-2115
Fax: (402) 471-0383

NEVADA

Nevada State Board of Nursing
2670 Chandler #9
Las Vegas, NV 89120
Phone: (702) 739-1575
Fax: (702) 739-0298

NEW HAMPSHIRE

New Hampshire Board of Nursing
Health & Welfare Building
6 Hazen Drive
Concord, NH 03301-6527
Phone: (603) 271-2323
Fax: (603) 271-6605

NEW JERSEY

New Jersey Board of Nursing
PO Box 45010
Newark, NJ 07101
Phone: (201) 504-6493
Fax: (201) 648-3481

NEW MEXICO

New Mexico Board of Nursing
4253 Montgomery Blvd., Suite 130
Albuquerque, NM 87109
Phone: (505) 841-8340
Fax: None

NEW YORK

New York State Board of Nursing
State Education Department
Cultural Education Center, Room 3023
Albany, NY 12230
Phone: (518) 474-3843/3845
Fax: (518) 473-0578

NORTH CAROLINA

North Carolina Board of Nursing
PO Box 2129
Raleigh, NC 27602
Phone: (919) 782-3211
Fax: (919) 781-9461

NORTH DAKOTA

North Dakota Board of Nursing
919 South 7th Street, Suite 504
Bismarck, ND 58504-5881
Phone: (701) 224-2974
Fax: (701) 224-4614

NORTHERN MARIANAS ISLANDS

Commonwealth Board of Nurse Examiners
Public Health Center
PO Box 1458
Saipan, MP 96950
Phone: 011-670-234-8950 through 8954
Fax: 011-670-234-8930

OHIO

Ohio Board of Nursing
77 South High Street, 17th Floor
Columbus, OH 43266-0316
Phone: (614) 466-3947
Fax: (614) 466-0388

OKLAHOMA

Oklahoma Board of Nursing
2915 North Classen Blvd., Suite 524
Oklahoma City, OK 73106
Phone: (405) 525-2076
Fax: (405) 521-6089

OREGON

Oregon State Board of Nursing
Suite 465
800 NE Oregon Street, Box 255
Portland, OR 97232
Phone: (503) 731-4745
Fax: (503) 731-4755

PENNSYLVANIA

Pennsylvania State Board of Nursing
PO Box 2639
Harrisburg, PA 17105
Phone: (717) 783-7142
Fax: (717) 787-7769

PUERTO RICO

Commonwealth of Puerto Rico
Board of Nurse Examiners
Call Box 10200
Santurce, Puerto Rico 00908
Phone: (809) 725-8161 or 7904
Fax: (809) 725-7903

RHODE ISLAND

Rhode Island Board of Nurse Registration & Nursing Education
Cannon Health Building
3 Capitol Hill, Room 104
Providence, RI 02908-5097
Phone: (401) 277-2827
Fax: (401) 277-1272

SOUTH CAROLINA

South Carolina State Board of Nursing
220 Executive Center Drive, Suite 220
Columbia, SC 29210
Phone: (803) 731-91648
Fax: (803) 731-1647

SOUTH DAKOTA

South Dakota Board of Nursing
3307 South Lincoln Avenue
Sioux Falls, SD 57105-5224
Phone: (605) 335-4973
Fax: (605) 335-2977

TENNESSEE

Tennessee Board of Nursing
283 Plus Park Blvd.
Nashville, TN 37247-1010
Phone: (615) 367-6232
Fax: (615) 367-6397

TEXAS—RNs

Texas Board of Nurse Examiners
PO Box 140466
Austin, TX 78714
Phone: (512) 835-4880
Fax: (512) 835-8684

TEXAS—VNs

Texas Board of Vocational Nurse Examiners
9101 Burnet Road, Suite 105
Austin, TX 78758
Phone: (512) 835-2071
Fax: (512) 835-1367

UTAH

Utah State Board of Nursing
Division of Occupational & Professional Licensing
PO Box 45805
Salt Lake City, UT 84145-0805
Phone: (801) 530-6628
Fax: (801) 530-6511

VERMONT

Vermont State Board of Nursing
Redstone Building
26 Terrace Street
Montpelier, VT 05602-1106
Phone: (802) 828-2396
Fax: (802) 828-2496

VIRGIN ISLANDS

Virgin Islands Board of Nurse Licensure
PO Box 4247, Veterans Drive Station
St. Thomas, U.S. Virgin Islands 00803
Phone: (809) 776-7397
Fax: (809) 777-4003

VIRGINIA

Virginia Board of Nursing
6606 West Broad Street, 4th Floor
Richmond, VA 23230-1717
Phone: (804) 662-9909
Fax: (804) 662-9943

WASHINGTON—RNs

Washington State Board of Nursing
Department of Health
PO Box 47864
Olympia, WA 98504-7864
Phone: (206) 753-2686
Fax: (206) 586-5935

WASHINGTON—LPNs

Washington State Board of Practical Nursing
Department of Health
1112 Quince Street SE
PO Box 47865
Olympia, WA 98504-7865
Phone: (206) 753-2807
Fax: (206) 753-1338

WEST VIRGINIA—RNs

West Virginia Board of Examiners for Registered Professional Nurses
101 Dee Drive
Charleston, WV 25311-1620
Phone: (304) 558-3596
Fax: (304) 558-3666

WEST VIRGINIA—LPNs

West Virginia State Board of Examiners for Practical Nurses
101 Dee Drive
Charleston, WV 25311-1688
Phone: (304) 558-3572
Fax: (304) 558-3666

WISCONSIN

Wisconsin Bureau of Health Service Professions
1400 East Washington Avenue
PO Box 8935
Madison, WI 53708-8935
Phone: (608) 266-0257
Fax: (608) 267-0644

WYOMING

Wyoming State Board of Nursing
Barrett Building, 2nd Floor
2301 Central Avenue
Cheyenne, WY 82002
Phone: (307) 777-7601
Fax: (307) 777-6005

Appendix G

Sample Forms and Letters for Delegation and Other Problems

1. AFT: Inappropriate Delegation.

2. UFT: Additional Staffing Request.

3. UFT: Unsafe Staffing Notification.

4. UFT: Medical Information Request Letter.

Letter to Administrator about Inappropriate Delegation

Following is a model letter that should be sent to the appropriate administrator when school personnel are asked to perform health care procedures which are outside their scope of training or responsibility.

PLEASE NOTE: Part of this letter depends on whether or not the Nurse Practice Act in your state permits delegation of nursing tasks to unlicensed personnel. Given the wide range of state and local laws and regulations on this and related issues, members and locals would be advised to seek the advice of their attorneys before using a letter like this one. The letter will need to be modified in accordance with their own State Nurse Practice Act, state education agency regulations and guidelines, and local school district policies and regulations. The letter must also reflect a sensitivity to any collective bargaining issues that may exist.

Date

Administrator
School
Street Address
City, State, Zip
Dear (Administrator's Name):

On [date] you informed me that I would be responsible for performing [name of nursing procedure] for a student in our school. You have [asked/directed] me to perform a duty that is not within the scope of my training or responsibilities as a [classroom teacher/paraprofessional]. I am writing because I feel that if I do what you have [asked/directed], I will be doing a disservice to the students and the [district/county name]. In addition, I may be acting in violation of the State Nurse Practice Act and subjecting myself to personal liability if anything should happen to the student.

It is my understanding that when a student enters the school system with a health problem [a registered nurse or school nurse], rather than school authorities, must perform an assessment, and develop and implement a plan for meeting the student's health needs. [It is my further understanding that the decision as to whether or not a specific nursing task can be delegated to an unlicensed person and the specification of training needs if the delegation occurs, must also be made by a registered/school nurse.] *(This depends on whether or not the Nurse Practice Act in your state permits delegation of nursing tasks to unlicensed personnel. In states that do not permit delegation, this sentence should be omitted.)* The State Nurse Practice Act provides that unlicensed persons who perform activities within the scope of nursing practice are subject to [criminal sanctions/administrative penalties in accordance with the state law] for the unauthorized practice of nursing. In addition, if the performance of the procedure by an unlicensed person results in a bad outcome for the student, the district and any of the unlicensed individuals involved in assigning or performing the task could be held liable by the courts.

While I am cognizant of and fully support the rights of our students to receive the medical assistance they need in order to attend school (as affirmed by the Supreme Court's Tatro decision), I believe that students' health care needs should be determined and attended to by a school nurse. In the absence of a school district policy which [complies/meets] with [state education department and/or state board of nursing] [requirements/guidelines], I request written assurance from board counsel that my actions will be considered as within the scope of my duty for liability purposes, that the school district will defend my actions in any [criminal/administrative] proceedings that may ensue, and that I will be held harmless from civil liability.

Very truly yours,
(Teacher/Paraprofessional)

cc: Superintendent
Local Union President
School District Attorney
Local Union Attorney
State Board of Nursing

FEDERATION OF NURSES/UFT
FNHP-AFL-CIO
260 Park Avenue South
New York, NY 10010
(212) 598-9563

ADDITIONAL STAFFING REQUEST

Date: ___/___/___

TO: ____________________ Supervisor: ____________________

FROM: __________________, RN School Site: __________________
(Please Print)

____
(Address)

==

Due to the increased caseloads, emergencies and first-aid to students I am requesting an evaluation for an additional staff nurse position at ___________________.
(School Site)

I feel the current staffing provided is no longer adequate to meet the nursing care needs of the students.

In the meantime, please assign additional staffing until an evaluation is completed.

Signatures: ____________________________
(School Nurse)

____
(Principal)

Please submit the original to your Supervisor. Make at least one copy for yourself and send a copy to B.J. Darby, UFT, 260 Park Avenue South, New York, NY 10010

FEDERATION OF NURSES/UFT
FNHP-AFL-CIO
260 Park Avenue South
New York, NY 10010
(212) 598-9563

UNSAFE STAFFING NOTIFICATION

Date: ___/___/___

TO: ______________________ Supervisor: __________________

FROM: ________________, RN School Site: ________________
(Please Print)

____
(Address)

===

On ____/____/____, I notified your office that the staffing at this school was no longer adequate to meet the needs of the students at this time.

Although a staffing evaluation was done and additional nursing staff was denied, it is my professional opinion that the health and safety of the students is being compromised.

Please be aware that while I will do all that I can to ensure safe and proper nursing care of my students, I fear that my/our efforts will not be sufficient.

Therefore, I am informing you that I/we can not take responsibility for any error or incidents that take place as a result of the unsafe staffing conditions the Board of Education has created.

Signatures: __________________________
(School Nurse)

FEDERATION OF NURSES/UFT
FNHP-AFL-CIO
260 Park Avenue South
New York, NY 10010
(212) 598-9563

Date: ____________________

Principal
School
Street Address
City,State,Zip

Dear (Principal's Name)

Attached is a list of students who entered our program since September 4, 1996.

As of this date, I still have not received current medical information regarding the health status of these students. Nor have I been successful in my efforts to obtain parental permission for the release of medical records from the child's' physician or medical clinic. This is a serious situation which needs your immediate attention.

The lack of medical information prevents me from performing the appropriate assessment, planning and treatment of students which can lead to a life-threatening situation. It also jeopardizes my employment and professional license.

I am bringing this to your attention so that you will assist me in obtaining medical records in order that the appropriate nursing care can be provided during the school day.

Very truly yours,

____
School Nurse

c Fran Goldstein, Executive Director
Division of Student Support Services
Simon Gourdine, Counselor to theChancellor
Office of Legal Services
Nilda Soto Luiz
Office of Monitoring and School Improvement
B.J. Darby, FNHP/UFT

Appendix H
Sample School Nursing Forms

1. Philadelphia School District: Protected Handicapped Students, Permission or Notice of Evaluation.

2. Board of Education of the City of New York: Medical History and Evaluation Form.

3. Philadelphia School District, Division of School Health Services: Pupil Health Status.

4. Board of Education of the City of New York: Annual Physician's Authorization for Treatments.

5. Philadelphia School District, Division of School Health Services: Service Agreement.

6. Board of Education of the City of New York: Individualized Healthcare Plan.

7. Board of Education of the City of New York: Parent/Guardian Notification.

8. Board of Education of the City of New York: Request for Referral.

9. Philadelphia School District, Division of School Health Services: Accommodation Referral: Student.

10. Philadelphia School District, Division of School Health Services: Request for Administration of Medication or Use of Suction, Oxygen, or Other Equipment in School.

11. Board of Education of the City of New York: Treatment Record.

12. Board of Education of the City of New York: Medication Administration Record.

13. Philadelphia School District: Pupil's Record of Medication Administered or Equipment Used.

14. Board of Education of the City of New York: Medication Inventory Sheet.

15. Board of Education of the City of New York: Nurse's Daily Schedule.

16. Board of Education of the City of New York: Nurse's Progress Notes.

THE SCHOOL DISTRICT OF PHILADELPHIA

DIVISION OF SCHOOL HEALTH SERVICES

PROTECTED HANDICAPPED STUDENTS
PERMISSION OR NOTICE OF EVALUATION

Name ____________________ ☐ Initial Evaluation
☐ Re-evaluation
Address ____________________ ☐ Modification

Phone ____________________ Date ____________________

Re: ____________________
Name of Student
____
PDIF#
____
D.O.B.

Dear Parent or Guardian:

In order to assure that your child who attends the ____________________ School has access to education the School District has determined:

☐ Evaluation is necessary because ____________________
☐ Evaluation will be conducted as you requested.

The evaluation may show that your child is eligible for a Service Agreement as a protected handicapped student. If so, you will be invited to help in preparing a Service Agreement for your child.

You have the following rights:

- To review your child's education records.
- To discuss your child's education records with someone who is authorized to answer your questions.
- To discuss the referral and proposed evaluation plan with a member of the school team.
- To give or withhold consent for all or part of the proposed evaluation plan. No initial evaluation can be conducted without your written consent or the approval of a hearing officer.
- To request a hearing about all or part of the proposed evaluation plan.

You can arrange to do any of the above by calling ____________________

The kinds of evaluation and proposed dates are given below:

Type of Evaluation	Proposed Date

Sincerely,

____
Principal

☐ No response is needed. Permission was previously given.
☐ Your response is needed. Please mark one response, sign below and return to the school nurse within 10 days.
☐ I agree to the proposed evaluation.
☐ I do not agree to the proposed evaluation because ____________________
____

Parent Signature ____________________ Date ____________

MEH-202 (9/92) – SDSN 445503
DISTRIBUTION OF COPIES: 1. CONFIDENTIAL FILE 2. PARENT 3. COMPLIANCE OFFICER

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

Student's Name__________ DOB__________ School__________ District__________ Program__________
Address__________ Home Telephone #__________
Parent/Guardian__________ Work Telephone #__________
Doctor's Name__________ Telephone #__________
Clinic Name__________ Telephone #__________
Hospital Name__________ Telephone #__________
Clinic #__________ Medicaid #__________ SS#__________
Transportation Plan__________

Medical Diagnosis/Brief History:

IMMUNIZATION: {}complete {}incomplete__________ {}PPD__________

NURSING INTAKE/ ASSESSMENT

Has the student have/had any of the following conditions:

__Asthma__________
__TB__________
__Diabetes__________
__Allergies__________
__High blood pressure
__Childhood diseases
__Kidney disease
__Skin disorders
__Heart disease
__Sickle cell disease__________
__Seizures__________
__Shunts__________
__Vision/hearing__________
__Others__________

COMMENTS__________

Medications:__________

Is the student prone to any of the following:

__Frequent colds__________
__Nosebleeds__________
__Diarrhea__________
__Vomiting__________
__Other__________
__Frequent earaches__________
__Headaches/dizziness__________
__Constipation__________
__GI problems__________

Diet and Feeding pattern:

__G-tube
__Type/Method__________
__Self feeder
__Prone to choking
__NPO
__Regular
__Mashed
__Chopped
__Puree
__Supplementive/Special Diet
__Dominant hand
__Uses spoon
__Uses fork
__Uses cup
__Uses straw

(Nur001)

Toileting Needs:

___Catheterization
___Needs assistance
___Self toilets
___Uses pampers
___Needs toilet training

Mobility:

___Ambulatory
___Special shoes
___Non-ambulatory
___Body jacket
___W/C
___Braces
___Walker
___Other

Behavior Problems:

___Temper tantrums
___Self abusive___________________
___Abuses others_________

Speech:

___Primary language__________
___Other
___Verbal
___Non-verbal
___Signs

Nursing Procedures____
____
____
____
____
____

Comments____
____
____
____
____
____
____

Parent/Guardian Signature________________________________ Date____________________

Nurse's Signature________________________________ Date____________________

DIVISION OF SCHOOL HEALTH SERVICES
PUPIL HEALTH STATUS

PUPIL'S LAST NAME	FIRST	BIRTH DATE	ROOM	BOOK NO.	GRADE
SCHOOL NAME	DISTRICT	DATE OF ISSUE			

To the Parent or Guardian:

Your child's health history ☐ / health record ☐ indicates that he/she has been under care for the following health problem(s):

It is important that the school nurse/practitioner have a record of the present health status of the student. Please fill in the following information and return to school nurse/practitioner immediately so he/she can better respond to the needs of your child.

1. Does the student's previous health problem(s) still exist? ______________________
2. Date the problem last occurred ______________________
3. Does he/she have other health problems? Yes ☐ No ☐. If yes, what are they? ______________________

____

____

4. Does he/she take medicine? Yes ☐ No ☐.

If yes, please give name of medicine ______________________

How much taken ______________ time(s) taken ______________

5. Does he/she regularly receive treatment/therapy or undergo any testing procedures? ______________

If yes, please indicate kind and how often taken ______________________

____

6. Name of doctor, clinic, health or medical center which cares for student ______________________

Address ______________________

Phone Number ______________________

Date of last visit ______________________

7. Special instructions concerning school activities ______________________

____

8. What do you do for your child if he/she has an attack/episode? ______________________

____

9. Parent/Guardian's Name ______________________

____

10. Home address ______________________ Home phone ______________
11. Place of employment ______________________ Work phone ______________
12. Name of emergency contact ______________________

Relationship to student ______________________ Phone ______________

For your child's protection return this form immediately	PARENT/GUARDIAN	DATE
SCHOOL PRINCIPAL	SCHOOL NURSE	

TO THE SCHOOL NURSE: Refer to School Health Services Procedure 803

S865 (Rev. 9/87) School District of Philadelphia

SDSN 445 860

NURSING PROCESS

1. Assement:

2. Plan:

3. Implementation:

4. Evaluation:

Comments to Receiving School Nurse/Practitioner (Medical Alert):

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*
OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

ANNUAL PHYSICIAN'S AUTHORIZATION FOR TREATMENTS

(Circle appropriate treatment)

Clean Intermittant Catheterization
Blood Glucose Monitoring
Gastrostomy Feeding
Naso-Gastric Feeding
Central Venous Line

Tracheotomy Care
Oral/Pharyngeal Suctioning
Tracheal Suctioning
Oxygen Administration
Ostomy Care

Chest Clapping
Percussion
Postural Drainage
Nebulizer Treatment
Dressing Change

Other____

STUDENT'S NAME____________________ DOB________ SCHOOL______________

1. Physical condition which necessitates nursing services:

2. Nursing services required:

3. Remarks and Comments:

4. Number of days per week nursing services required:

PHYSICIAN'S NAME
PHYSICIAN'S SIGNATURE
PHYSICIAN'S ADDRESS

PHYSICIAN'S PHONE NUMBER
NYS REGISTRATION NUMBER
DATE SIGNED

I, hereby, authorize a Board of Education Nurse to perform this treatment on my child.

Parent/Guardian Signature

Date

(Nur004)

THE SCHOOL DISTRICT OF PHILADELPHIA

DIVISION OF SCHOOL HEALTH SERVICES

SERVICE AGREEMENT

STUDENT'S NAME			REGION
ADDRESS			TODAY'S DATE
PHONE		ZIP CODE	REVIEW DATE
D.O.B.	GRADE	PDF #	

SIGNATURES OF PERSONS PARTICIPATING IN THE SERVICE AGREEMENT PLANNING CONFERENCE

PARENT

CERTIFIED SCHOOL NURSE

OTHERS (NAME AND TITLE)

ASSIGNMENT OF RELATED AIDS, ACCOMODATIONS, SERVICES	START DATE	DATE OF DISCONTINUATION

☐ Check if above is a modification of services

☐ I agree to the service agreement.
☐ I do not agree because:

Signature ____________________

IF APPLICABLE, PROCEDURES TO BE FOLLOWED IN THE EVENT OF A MEDICAL EMERGENCY

NAME OF SCHOOL ASSIGNMENT	SCHOOL ADDRESS
NAME OF PRINCIPAL	PHONE
COMPLIANCE OFFICER (NAME AND TITLE)	

MEH-203 (9/92) – SDSN 445504

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BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*
OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

INDIVIDUALIZED HEALTHCARE PLAN

Student's Name____________________________________

Date____

Nurse's Signature____________________________________

School__________________________

Date Completed__________________

GOALS:

NURSING DIAGNOSIS	NURSING INTERVENTIONS	EVALUATION

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

PARENT/GUARDIAN NOTIFICATION

Date____________________

Dear________________________________

Your child_________________________was seen in the health office today for the following reason:____

____

____

____

It is advisable that you do the following:

____

____

____

____

____

____

____

(nuroo5)

____
School Nurse

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

SCHOOL ____________________

REQUEST FOR A REFERRAL

DATE ____________________

NAME ____ DOB ____________________

ADDRESS ____

DEAR PARENT:

It is advisable for you to consult your family doctor regarding the following:

____

____

____

____

____

NAME ____________________

TITLE ____________________

DEAR DOCTOR:

Will you please give your opinion and recommendations below:

Findings and opinion ____

____

____

____

Recommendations ____

____

____

____

Signature ____________________ **Telephone #** ____________________

Address ____

(NUR002)

THE SCHOOL DISTRICT OF PHILADELPHIA
DIVISION OF SCHOOL HEALTH SERVICES
ACCOMMODATION REFERRAL: STUDENT

☐ INITIAL REFERRAL
☐ CHANGE OF STATUS
☐ PROGRAM MODIFICATION

STUDENT NAME (Last, First, Middle Initial)	DATE OF BIRTH	SCHOOL	PDIF#	GRADE/PROGRAM	ROOM	SEX M/F (Circle)

ADDRESS	PARENT/GUARDIAN	PHONE #	DATE OF RECORD	REFERRED BY

SOURCE OF REFERRALS

REASON FOR REFERRALS

PRIOR STRATEGIES USED AND RESULTS OF EFFORTS TO MEET STUDENT'S NEEDS: (Include parental involvement)

SCHOOL SUPPORT TEAM RESPONSE

☐ CONDUCT EVALUATION AND NOTIFY PARENT
☐ DEVELOP WRITTEN SERVICE AGREEMENT
☐ RETURN TO ______________________________ FOR ADDITIONAL INFORMATION
☐ NO ACTION NECESSARY AT THIS TIME
☐ PARENTAL CONSENT
☐ OTHER (specify) ______________________________

SIGNATURES/
TITLES:

NAME ______________________ TITLE ____________ DATE ____________

NAME ______________________ TITLE ____________ DATE ____________

MEH-200 (9/92) – SDSN 445501

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AMERICAN FEDERATION OF TEACHERS

THE SCHOOL DISTRICT OF PHILADELPHIA
DIVISION OF SCHOOL HEALTH SERVICE

REQUEST FOR ADMINISTRATION OF MEDICATION *or* USE OF SUCTION, OXYGEN *or* OTHER EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE:
Do not leave any blank spaces. This form will be returned to you which will cause a delay in your patient receiving medication/equipment.

NAME OF PATIENT/PUPIL	ADDRESS/ZIP		ROOM/BOOK NO
DATE OF BIRTH	SCHOOL/LOC #	REGION	PDIF

DIAGNOSIS

REASON MEDICATION MUST BE GIVEN IN SCHOOL

NAME OF MEDICATION/EQUIPMENT/TREATMENT	DOSE
TIME(S) TO BE GIVEN IN SCHOOL	TOTAL DOSAGE PER 24 HRS
DATE BEGIN	DATE END

INSTRUCTION FOR ADMINISTRATION/UTILIZATION

CONTRAINDICATIONS

SIDE EFFECTS

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN

IS ANY RESTRICTION ON ACTIVITY NECESSARY YES ☐ NO ☐

IF YES, DESCRIBE

IS PUPIL TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

I

To The Principal

I authorize selected school personnel to administer the above medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to contact my child's health care provider as needed regarding this medication/equipment and/or my child's response.

PARENT SIGNATURE ______ TELEPHONE NUMBER ______

DATE SIGNED ______ EMERGENCY NUMBER ______

• •

II

TO BE COMPLETED BY SCHOOL NURSE AFTER REVIEW AND PRIOR TO SUBMISSION TO SCHOOL HEALTH SERVICES (SUBMIT ALL THREE COPIES)

SIGNATURE OF SCHOOL NURSE ______

TELEPHONE NUMBER ______ DATE SENT TO SHS ______

• • • • • • • • • • • • • OR • • • • • • • • • • • • •

III

IN ACCORDANCE WITH CURRENT SCHOOL HEALTH SERVICES PROCEDURE, THE ADMINISTRATION OF THIS MEDICATION COMMENCED ON ______ (DATE)

(RETAIN THE SCHOOL COPY)

SIGNATURE OF SCHOOL NURSE ______

TELEPHONE NUMBER ______ DATE SENT TO SHS ______

• •

IV

FOR THE DIVISION OF SCHOOL HEALTH SERVICES USE ONLY

DATE RECEIVED ______ DATE APPROVED ______

DATE COPY SENT TO SCHOOL NURSE ______ DATE COPY SENT TO RNS ______

SIGNATURE OF SCHOOL HEALTH SERVICES PHYSICIAN/ADMINISTRATOR ______

MED-1 (REV3/95) - SDSN 445400 DISTRIBUTION OF COPIES: WHITE - *SCHOOL NURSE,* YELLOW - *SCHOOL HEALTH SERVICES,* PINK - *NURSE SUPERVISOR,* GOLD - *PARENT*

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET - BROOKLYN, NY 11201

TREATMENT RECORD

DATE	TIME	TREATMENT	RESULT	COMMENTS

(NUR012)

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET · BROOKLYN, NY 11201

MEDICATION ADMINISTRATION RECORD

School Year__________ School________________________ District_________ Program____
Student_______________________________ DOB________ Teacher____________________ Class____________ Room________
Medication________________________ Route________________ Dose______________ Time______________ Start Date________
Physician________________________ Physician Address________________________________ Phone______________________

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

Int	Full Name	Signature
___	__________	______________________
___	__________	______________________

THE SCHOOL DISTRICT OF PHILADELPHIA

PUPIL'S RECORD OF MEDICATION ADMINISTERED OR EQUIPMENT USED

ACCESS ELIGIBLE
☐ YES
☐ NO

SCHOOL YEAR

PUPIL'S NAME: ____________ DATE OF BIRTH: ________ SC# ____________ PDIF ________

SCHOOL: ____________ LOC# ________ REGION/CLUSTER: ____________ RM./GR ________ SELF ADM. ☐ YES ☐ NO

NAME OF DRUG/EQUIPMENT (Give dosage & route as ordered on MED-1 and Special Instructions)	TIME	DATE																														
MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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PROGRESS CODE																																

INSTRUCTIONS

SIGN FULL SIGNATURE, TITLE AND INITIALS AT BOTTOM RIGHT

INITIAL EACH DOSE/ADMINISTRATION GIVEN.

INSERT PROGRESS CODE FOR ACCESS

SIGNATURE	TITLE	INITIALS

MED-2 (Rev 6/95)

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET · BROOKLYN, NY 11201

Student's Name____________________ DOB______ School______________ District_______ Program________

MEDICATION INVENTORY SHEET

Date	Medication & Dose	Amount on Hand	Comments	Nurse's Signature

BOARD OF EDUCATION OF THE CITY OF NEW YORK
RAMON C. CORTINES, *Chancellor*

OFFICE OF THE CHANCELLOR
110 LIVINGSTON STREET · BROOKLYN, NY 11201

NURSE'S DAILY SCHEDULE

8:00AM	
8:15AM	
8:30AM	
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2:30PM	
3:00PM	

(NUR010)

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NURSE'S PROGRESS NOTES

(NUR011)

Appendix I

Transporting the Special Needs Student

1. XIIth National Conference on School Transportation:
National Standards for School Buses and School Bus Operations

Reprinted with permission by the Twelfth National Conference Steering Committee.
Note: The following pages are excerpts from this resource.
For the full document, call the number on the following cover page.

NATIONAL STANDARDS FOR SCHOOL BUSES
and
SCHOOL BUS OPERATIONS

1995 Revised Edition

Recommendations of

THE TWELFTH NATIONAL CONFERENCE ON SCHOOL TRANSPORTATION

Central Missouri State University
Warrensburg, Missouri
May 21 - 26, 1995

Co-Sponsored by:

National Association of State Directors of Pupil Transportation Services
National Association for Pupil Transportation
National School Transportation Association
School Transportation Section, National Safety Council
School Bus Manufacturers Institute
Central Missouri State University

This Publication is available from:
Missouri Safety Center
Central Missouri State University
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Warrensburg, MO 64093
(816) 543-4830

Foreword

The 1995 National Conference on School Transportation was the latest in a series beginning in 1939 and continuing in 1945, 1948, 1951, 1954, 1959, 1964, 1970, 1980, 1985 and 1990. All conferences have been made up of official representatives of State Departments of Education, Public Safety, Motor Vehicles, and Police or other state agencies having statewide responsibilities for the administration of pupil transportation, local school district personnel, contract operators, advisors from industry and from other interested professional organizations and groups. Each conference has resulted in one or more publications that contain the recommendations of that particular conference.

The recommendation of standards for school buses and their operation has been a major purpose of all conferences. The 1939 Conference was called for the sole purpose and formulated a set of recommended standards for school buses of 20 or more passengers. The 1945 Conference revised the 1939 recommendations and added standards for small vehicles of 10 to 18 passengers. Both standards were further revised by the 1948 Conference. There were additional revisions in 1959, and the 1964 Conference added standards for school buses to be used in transporting handicapped children. In addition to revising standards for larger vehicles, the 1970 Conference refined the standards for school buses designed to transport fewer than 24 passengers.

Other major problems in pupil transportation have received attention at these National Conferences. On several occasions, recommendations concerned primarily with overtaking and passing of school buses were transmitted to the National Committee on Uniform Traffic Laws and Ordinances for consideration in connection with revisions of the Uniform Vehicle Code. The 1948 Conference made recommendations on uniform records and reports for pupil transportation. The major purpose of the 1948 Conference was the formulation of recommendations related to standards and training programs for school bus drivers. These recommendations were revised by the 1959 Conference, and a new publication on the topic was issued. The 1954 Conference gave considerable time to the discussion of the extended use of the school buses in the school program. The 1970 Conference also adopted standards for school bus operation (issued in a separate report).

The 1980 Conference updated the standards for school bus chassis and bodies, rewrote the complete standards for the special education bus, and included definitions for the Type A, B, C and D bus. One of the major tasks of the 1980 Conference was to revise the standards to remove any conflicts with superseding federal regulations, many of which were mandated by sections of the Motor Vehicle and School Bus Safety Amendments of 1974 (Public Law 93-492).

The 1985 Conference updated the standards for school bus chassis, body, special education and operations procedures. A major project was completed in the adoption of a uniform school bus accident report form. This form was designed to standardize school bus accident data reporting throughout the school transportation industry. Major issues such as safety inside the vehicle, loading and unloading, emergency procedures, and special education were discussed with appropriate resolutions passed for future research and implementation.

The 1990 Conference removed the word "minimum" from the title of the Conference publication. The format of the Conference publication was reorganized into two parts, "Standards for School Buses and Standards for Operations". All sub-parts such as accident reporting and special education transportation were incorporated into the section on the school bus or the section on operations.

A major change was incorporated into the procedures for the 1990 Conference. Any mandatory standard could be recommended for a special vote for forwarding action to the appropriate federal agency with a request for rulemaking. This rulemaking request would be an attempt to have the standard, adopted at the Conference, become a federally mandated requirement. For this forwarding action to be approved, any such item had to receive two-thirds affirmative vote. The delegation approved forwarding action on standards for mirrors, emergency exits, accident reporting and special education transportation. This procedural change was carried forward for the 1995 Conference.

The 1995 Conference was the first to begin to address the expanded role of pupil transportation as prescribed in the revised Highway Safety Program Guideline #17 - Pupil Transportation Safety. The revised guidelines became effective May 29, 1991 and this was the first Conference convened since its adoption. Transportation of pre-kindergarten age students including infants and toddlers was addressed for the first time. A comprehensive section dealing with the use of alternative fuels in school bus operations was discussed and included in the publication. A new section, Terms and Definitions, was added to the appendices to promote consistency throughout the industry, to consolidate into one resource the acronyms, abbreviations, and standard terms used in the industry, and to provide easy access to definitions of terms used or referenced within the document.

One writing committee spent significant time and energy developing materials for discussion, and possible adoption, related to the safety considerations for students who are now or who may be transported to and from school in Urban Transit System buses. While the conference delegations adopted many new and far-reaching standards, they were not ready to entertain the section on transit use. Discussion was terminated without a full presentation of the prepared materials.

With the enactment in 1966 if the National Traffic and Motor Vehicle Safety Act, the federal government was given responsibility for developing and promulgating motor vehicle safety standards for motor vehicles sold in the United States. These Federal Motor Vehicle Safety Standards (FMVSS) are continually evaluated and revised as needed. Such standards in their present form or as subsequently amended will void any action taken during the 1995 Conference wherever there is a conflict. Whenever standards adopted by the 1995 Conference go beyond, or are in addition to the FMVSS, they remain valid.

The structure for the 1995 Conference and its operating guidelines was carried out by the Steering Committee. Funding for the conference was shared solely by each individual participant of the Steering Committee, Writing Committees and all delegates at the conference.

—DON M. CARNAHAN
General Conference Chairman

Objectives and Guiding Principles

Since the first National Conference on School Bus Standards in 1939, certain objectives and guiding principles had a vital role in the development of the standards for school buses and their operation. Objectives and guiding principles have been reaffirmed and emphasized at subsequent National Conferences. The two major objectives, safety and economy, along with the following principles, have served as guideposts for making decisions on the standards and in arriving at sound and common agreement.

OBJECTIVES

The transportation of pupils in safety and comfort on safe, economical vehicles can be assured through adequate state regulations governing school bus construction and their mode of operation. Safety includes all those factors relating to the school bus construction and modes of operation which may directly or indirectly affect the safety and welfare of pupils transported.

Economy includes the construction, procurement, operation, management, and maintenance of school buses and staff consistent with the safety and welfare of the pupils.

GUIDING PRINCIPLES

1. Uniform state standards for school buses and their mode of operation should:
   a. Be consistent with the objectives of safety and economy.
   b. Eliminate the construction and use of unsafe buses.
   c. Reduce conflicting standards wherever possible among states in the interest of production efficiency and operation effectiveness.
   d. Specify exact dimensions where necessary to increase the efficiency of volume production.
   e. Eliminate unnecessary luxury consistent with the safety and welfare of the pupils transported.
2. Any adaptation of the nationally recommended standards should only be made by states in order to permit desirable adjustments to local needs and only when such adaptations do not:
   a. Conflict with the recommended National Standards.
   b. Conflict with FMVSS.
   c. Conflict with the National Highway Traffic Safety Administration's Highway Safety Guideline #17 - Pupil Transportation Safety.
   d. Otherwise unduly increase operation or production costs.
3. Uniform state standards for school buses should specify results desired in terms of safety and economy, and these performance specifications must be defined when necessary to make the regulation enforceable.
4. Provisions should be made for periodic review and revision of uniform state standards for school buses and their operation through cooperation of the states.
5. Uniform state standards for school buses and their operation should permit opportunities for the use of new inventions and improvements which are consistent with safety and economy.
6. Uniform state standards for school bus construction should provide for a degree of flexibility within which sound construction is possible (consistent with safety and economy) to accommodate the various manufacturers.
7. Uniform state standards for school bus construction should recognize that the actual designing of school buses is a responsibility of the manufacturers.
8. The current National Standards for School Buses are considered in full force and effect as recommendations to the states. Revisions of these standards are made only when evidence indicates that such revisions are needed.

Special Needs Student Transportation

The purpose of this section is to recommend standard policies, procedures, and guidelines for persons entrusted with the responsibility of managing transportation for students with special needs. The term "SPECIAL EDUCATION" means " specifically designed instruction to meet the unique needs of a child with a disability". Transportation is one of the "related services" required when necessary to provide such instruction.

The guidelines, policies, and procedures recommended, though general in nature, do contain adequate information to guide those persons responsible for pupil transportation in developing an action plan for the safe delivery of transportation for students with special needs.

This section reviews the current laws governing special transportation related to the individualized education program process, recommended staff training, and policy development.

The transportation administrator and pertinent staff should become familiar with the following laws, guidelines, policies and procedures:

LAWS AFFECTING SPECIAL NEEDS STUDENT TRANSPORTATION

1. Laws

a. Section 504 of P.L. 93-112, a part of the Rehabilitation Act of 1973, states in part:

"No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." .... It is possible for a school district to be required to provide specialized transportation services to a student with disabilities who is not in special education.

***

c. The reauthorization of the Education of the Handicapped Act changed the name to Individuals with Disabilities Education Act (IDEA). P.L. 101-746., passed in 1990. This reauthorization increased the number of related services from 13 to 17. It did not change transportation's status as a related service. The reauthorization did not change the original definitions of transportation that were listed in the Education of the Handicapped Act.

Of note for transporters; the "Non-Academic Services" section, under the Free Appropriate Public Education component of IDEA requires the public agency to "provide non-academic and extracurricular services and activities in such manner necessary to afford children with disabilities an equal opportunity for participation in those services." Obviously, one of those non-academic services is transportation. This continues the emphasis to integrate children with disabilities as much as possible with children without disabilities.

***

3. Related services

As part of the mandate of a free appropriate public education, "Related services" are required when determined necessary to assist a child with a disability to benefit from special education. Transportation is a related service under IDEA, and is defined to include:

a. Travel to and from school and between schools.

b. Travel in and around school buildings.

c. Specialized equipment (such as special or adaptive buses, lifts, and ramps) if required to provide special education for a handicapped child.

THE IMPLEMENTATION PROCESS FOR IDEA

1. Identification and Referral of Students for Special Education

a. ....Transportation staff should recommend to appropriate school administrators that a referral be initiated or the IEP team reconvened if there is reason to suspect a child has a disability or, if the child already is identified as having a disability, there are changes in the child's behavior or performance.

b. .....A transportation representative can be included in the assessment process and/or should be consulted prior to the IEP meeting. As the evaluation team gathers information for appropriate evaluation of the suspected disability, indications will be evident as to whether the student will .....need transportation as a related service, the type of specialized transportation service required, and if specialized care, intervention or training in blood borne pathogens and universal precautions is required as a result of a medical or health problem, a chronic disease, a contagious or communicable disease, or other reasons.

2. *The Role of Transportation Staff in the Assessment Process:*

When the evaluation team determines that a student may need transportation as a related service, and has characteristics which could require care, or intervention, which would exceed that required for a student without a disability, or require the use of adaptive or assistive equipment, the pupil transportation administrator shall be notified and the appropriate transportation staff invited to participate in the evaluation process as a resource person.

a. The transportation staff person could be expected to serve two major functions as a member of the evaluation team.

(1) The primary function would be to gather information regarding the student's expected transportation needs so as to properly plan for a timely, efficient, and safe initiation of transportation service.

(2) The secondary function would be to educate the evaluation team members regarding the transportation environment. This could include such things as the type and configuration of the vehicle the student would likely be assigned to ride, the probable length of ride, conditions with respect to temperature extremes during loading/unloading and on the bus (as an example, the lift door might be open for ten minutes on numerous occasions during pick up/drop off during sub-zero temperature), the type of device/occupant securement system to be used, if the vehicle is equipped with an emergency communication system, the degree of training and skills of the driver, if a bus attendant would be assigned without specific suggestion from the evaluation team, etc.

3. *Evaluation and Planning Relative to a Student's Special Transportation Needs:*

Assuming information being developed by the evaluation team indicates a need for transportation as a related service, and the student will likely need special care or intervention during transportation, or has adaptive or assistive equipment needs, transportation staff participation on the assessment team is essential in helping develop information which could address the following concerns:

a. Can the student be safely transported, given the transportation environment, including the length of the ride, without undue risk to the student or others?

b. Does the student have medical health, physical or behavioral concerns which would expose the student to unreasonable risk given the anticipated transportation environment?

c. Can assistive or adaptive equipment identified as necessary to accommodate the student during the transportation process be safely secured and transported, and are there adequate instructions regarding its use? For example, every effort should be made to avoid transporting a student on a gurney or stretcher-type mobility device, or one that reclines more than 45 degrees.

d. Education and transportation staff may lack the professional expertise and skills to make expert decisions regarding the above issues. The IEP meeting may include participants who are qualified to assist in determining transportation needs, particularly where significant medical or behavioral concerns are identified. When appropriate, a health care plan for the student should be developed which specifies the type and frequency of care required or expected, the skill level of the person expected to give the care, recommendation when general observation of the student by the driver would be adequate, or if a staff person independent of the vehicle driver is needed for the care or intervention of the student's needs.

e. Questions regarding the effect of necessary transportation services, (i.e., length of ride and/or time spent on the bus) on the student's ability to benefit from the planned program should be addressed.

f. Questions regarding appropriate and safe use of assistive or adaptive equipment, including mobile seating devices, ventilator or oxygen equipment, can be referred to such persons as physical therapists, occupational therapists, rehabilitation engineers, or equipment vendors for advice.

INDIVIDUALIZED EDUCATION PROGRAM (IEP) INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)-TEAM

........If it is determined that a student needs transportation as a related service, and needs care or intervention exceeding that required for a non-disabled student, or needs adaptive or assistive equipment, transportation staff shall be invited to be a participant on the IEP.

1. Legal Considerations: By law, this committee must consider several issues related to the student's educational program. When transportation is considered as a related service, there are a number of questions which must be addressed:

a. Can the student utilize regular transportation?

b. If not, can regular transportation be safely utilized if supplementary staff, equipment, and/or services are provided?

c. If not, what type of specialized transportation is required?

d. Is an attendant or other qualified personnel available?

e. Is a responsible adult available for pick-up and delivery of students?

2. Options: In addition to the above considerations, it is often necessary to review various alternative transporta-

tion options to meet a student's needs. Some alternatives frequently considered, and which must be allowable when determined appropriate are:

a. Parent or relative providing transportation.

b. Public or private transportation.

Note: Consideration needs to be given to the Continuum of Transportation Services available to students with disabilities. A sample Continuum of Services is provided on page 122.

3. Service Statement: The Individualized Education Program is a written statement of services a student is to receive. The IEP can only be changed by the IEP team. With regard to transportation, the IEP should provide the necessary specificity so the driver, school, parent and student know what services to expect.

4. IEP Staff: While participating on an IEP Team, a transportation staff member should be particularly vigilant so as to challenge transportation requirements that would be impossible to provide (such as a maximum riding time of 30 minutes when the student lives 45 minutes from school), or appears to be unsafe, or is not understood.

5. Discussion of. Concerns: If at some point after transportation has been implemented, the driver, attendant, or transportation director find the transportation plans unsafe, a student's behavior changes so dramatically as to create an unsafe environment, or the transporters need more information or assistance from the special education staff, any of the personnel listed can call an IEP meeting to discuss the concerns.

GUIDELINES

The following guidelines are intended to assist in establishing a training program for transportation staff that will enable them to respond to the concerns presented by special needs students (which is required by IDEA) and provide transportation staff with the skills needed to respond to routine and emergency circumstances during transportation.

1. School/Education Administration:

School administrators and education staff who make program decisions for special education students, including the requirement for transportation as a related service, are frequently unfamiliar with transportation capabilities and limits. Those persons should have training in areas which would include:

a. Situations under which transportation staff would be consulted, or included in the IEP Team process.

b. A knowledge of state and local transportation policies and procedures, including communications and reporting procedures.

c. A general knowledge of transportation regulations which could assist in determining if transportation would be appropriate as a related service.

d. A general knowledge of alternative transportation options.

e. A general knowledge of current legislative, legal, and administrative decisions.

f. A general knowledge of the application of Least Restrictive Environment (LRE) regulations to transportation placements.

g. A general knowledge of the extent of training and skill levels available within the transportation staff.

h. The types of vehicles used for special transportation.

i. The types of equipment and occupant securement systems used.

j. A general knowledge of Do Not Resuscitate (DNR) policies for local school districts as well as current legislative and administrative decisions concerning this topic.

2. Transportation Administration:

With increased responsibility being imposed on special education transportation providers through actions taken by legislative, legal, and administrative authorities, transportation administrator/supervisors must involve themselves in the leadership role to a greater degree than that which is usually necessary for other types of transportation.

While the duties and responsibilities of a transportation administrator/supervisor most likely would differ between various transportation providers, there are common areas of knowledge that are necessary to satisfactorily perform the responsibilities of an administrator/supervisor. Some are:

a. Knowledge of federal, state, and local laws and regulations regarding the equipment required on vehicles used for special education student transportation.

b. Knowledge of federal, state, and local laws and regulations regarding special education staff.

c. Knowledge of operational regulations such as student pick up/drop off, including whether curb to school, or door to school.

d. A general knowledge of special education transportation regulations, such as student riding time, and suspension period limitations.

e. A general knowledge of a special education student's due process rights and procedures.

f. A general knowledge of the student referral, evaluation and IEP process.

g. A general knowledge of the identity of resource persons and the location and availability of appropriate training.

h. A general knowledge of vehicle staffing requirements, including when an attendant might be needed.

i. A general knowledge of the availability of emergency medical services in the community who could assist if such an emergency were to occur during transportation.

j. A general knowledge of state and local laws relating to child abuse and reporting procedures.

k. A general knowledge of state or local laws relating to limits of liability, and policies and procedures for risk management.

l. A general knowledge of federal and state rules of confidentiality.

m. A general knowledge of legislative and administrative decisions and procedures concerning DNR.

3. *Drivers and Attendants:*

Drivers and attendants, as the direct service providers with hands-on responsibility, must operate special equipment, manage student behavior, administer health care, according to their qualifications, and serve as a seating specialist in positioning and securing adaptive and assistive devices and occupants.

a. Selection and retention of transportation staff

The responsibilities frequently differ so substantially between the role of the non-disabled student transportation staff and the student with disabilities transportation staff that while some staff feel comfortable transporting and associating with one category of student, they prefer not to be associated with the other category of student. Thus, it is important to explain fully to applicants for special education transportation staff positions the full implications of the duties expected. By eliminating applicants prior to hiring who would not feel comfortable performing some required services, staff retention level for this group will be relatively high. Staff retention is critical given the considerable costs associated with the extra training required. Having staff who have a continuing personal knowledge of the specific needs of individual students is a tremendous asset to their care.

b. Training components

To perform the responsibilities assigned in a safe and effective manner requires a substantial degree of specific training. Some components which would be beneficial to transportation's staff are:

(1) Introduction to special education, including characteristics of handicapping conditions, the student referral, assessment, IEP process, and protecting confidentiality of student information.

(2) Legal issues, including federal and state law, administrative rules and local policy.

(3) Operational policies and procedures, including:

(a) Loading/unloading.

(b) Pick up/drop off (curb to curb-door to door).

(c) Evacuation procedures.

(d) Lifting procedures.

(e) Student accountability and observation, including evidence of neglect, abuse.

(f) Post trip vehicle interior inspections for students, medicine, and other articles left prior to parking vehicle.

(g) Reporting procedures and report writing.

(h) Record keeping.

(i) Lines of responsibility relative to role as educational team member.

(j) Lines of communication, including parents and educational staff.

(k) Route management, including medical emergencies, no adult at home, inclement weather, field trips.

(l) Behavior management, including:

  i. Techniques for the development of appropriate behavior.

  ii. Techniques for the management and extinguishing of inappropriate behavior.

  iii. Techniques and procedures for the response to unacceptable behavior.

  iv. Procedures for dealing with inappropriate or unacceptable behavior that creates emergency conditions, or poses a risk to health and safety.

  v. Procedures for documenting and reporting inappropriate or unacceptable student behavior.

  vi. Techniques and procedures for the response to unacceptable behavior including the possession and transportation of illegal weapons or drugs, gang activities, and harassment.

(m) Blood borne pathogens and universal precaution procedure including the use of personal protective equipment.,

(n) Policies and procedures that ensure the confidentiality of personal identifying information.

4. *Special Equipment Use and Operation:*

There is a wide variety of equipment being identified to accommodate special education students that is required to be part of the transportation vehicle's environment. It is necessary for the transportation staff to be familiar with the design and operating procedure for this special equipment, as well as knowing how to conduct equipment inspection and make simple "field adjustments" during breakdowns. Some examples are:

a. Power lifts or ramps.

b. Emergency escape exits, including doors, windows and roof hatches.

c. Special fire suppression systems.

d. Power cut-off switch.

e. Emergency communications system.

f. Air conditioning system.

g. Mobile seating device, including trays and accessories, securement system hardware, and occupant securement systems.

h. Adaptive and assistive devices used to support or secure students, mobility aids, special belts, harnesses and devices (such as special crutches, braces, or wheelchairs, and including assistive technology devices)

i. All specially equipped school buses should be equipped with electronic voice communication systems which may be provided and installed by the body manufacturer, distributor, school district, operator or other party.

j. Service animals can be transported to assist the student with disabilities. District policies and procedures, as well as training, need to be established prior to transport.

5. *Medical/Health Issues:*

As a result of new regulations, which are making educational opportunities available to more special education students who have severe medical/health conditions, the transportation staff is finding it necessary to provide both routine and emergency health care to students during the transportation process. Additionally, transportation staff may be exposed to infectious or communicable diseases which could be debilitating, or in extreme circumstances, fatal. Training regarding medical/health issues can be divided reasonably into two categories, precautionary handling, and care and intervention.

a. Precautionary handling
All transportation staff, including drivers, attendants, mechanics, and service personnel, such as washing and cleaning staff, should be trained in universal precautions relative to the handling and exposure to contagious and communicable disease, including available immunizations. Suggested topics could include:

(1) Characteristics of contagious and communicable diseases.

(2) Disease management techniques.

(3) Use of protective equipment and devices.

b. Care, intervention, and management.
Medically fragile, technology dependent, and highly disruptive students require specific care and intervention. Proficiency in basic first aid and cardiopulmonary resuscitation provides adequate training to provide most health concerns during transportation. For those students who need additional care, management, or intervention, or present specific health risks, a care plan shall be developed during the assessment/evaluation process by the IEP Team which would specify and provide the transportation the following:

(1) A brief description of the student's current medical, health, or behavioral status, as well as an emergency care card with information on address, emergency phone numbers, etc.

(2) A description of the medical/health care or intervention necessary during transportation, including the frequency required.

(3) A description of who should provide the care or intervention.

(4) The type and extent of training or skills necessary for the driver and/or attendant.

(5) The inspection, operation, use and care of the student's adaptive/assistive equipment including items such as oxygen containment systems, auctioning equipment, Apnea monitors, ventilation equipment, etc.

(6) A description of emergency procedures to be implemented during a medical/health crisis, including communication with medical staff.

(7) A description of the procedures to be followed in changing the care plan when conditions indicate a change is warranted.

CONFIDENTIALITY

Information provided to transportation staff to assist in the orderly and safe transportation of a student, including handicapping condition, medical/health issues, or other personal characteristics or information, is protected by the provisions of the Family Educational Rights and Privacy Act (FERPA), and transportation staff shall be trained regarding confidentiality requirements.

DEVELOPMENT

In special education, there are any number of laws, rules, and regulations which dictate the service that must be provided, but few of them offer directions or suggestions as to how the service is to be provided. To guarantee a uniform and safe delivery of transportation service, and provide consistent directions to a transportation staff made up of persons with different personalities, temperament, and decision-making capabilities, an adopted written local school board adopted transportation policy and procedure directives shall be required.

1. Subjects Which Need Policy and Procedure Directives:

a. Control of student medicine transported between home and school on a vehicle.

b. Student suspension.

c. Physical intervention and management.

d. Authority to use special harnesses, vest, and belts.

e. Early closing of school due to inclement weather or other emergencies.

f. Authority to operate special equipment (driver, attendant, parent, students, school staff, others).

g. When no adult is home to receive students.

h. When to exclude special equipment which has a different design or configuration than last used, has tears or breaks in the fabric or metal.

i. When students are referred for transportation without sufficient information being available to transportation staff to protect their safety.

j. Student pick up/drop off location (one location specified, or unlimited alternative locations allowed).

k. Control and management of confidential information.

l. When and how to involve community emergency medical/law enforcement personnel.

m. When to use wheelchairs and mobility aids as pupil seating on school buses if the manufacturer of said device does not endorse its use as such; recognizing that in many situations the safe, economical and prudent way to transport a child is in his/her wheelchair/mobility aid.

n. District policy for Do Not Resuscitate (DNR) requests from parents, to include all appropriate school and transportation personnel. (Classroom and school bus policies may be different).

o. Driver and attendant responsibilities regarding DNR orders.

2. Policy Approval:

All policies shall be in writing, and formally approved by the appropriate education authority. Procedures may include establishing time lines for periodic reviews or revisions.

****

APPENDIX F

PROCEDURE FOR LIFTING PASSENGERS

PURPOSE: The purpose of proper lifting techniques is to move the passenger without injury to yourself or the passenger.

Basic Rules

1. Tell the passenger what you are going to do.

2. Estimate the weight of the passenger. (NEVER ATTEMPT TO CARRY A STUDENT ALONE WHO WEIGHS MORE THAN HALF YOUR OWN WEIGHT unless the safety of the student is in immediate danger, and no assistance is available.)

3. Always attempt to get help if you have any doubts about your ability to lift the student. If there is only a driver on a bus, and the necessity for an emergency evacuation develops, some districts suggest that the driver activate the alternating red lights, as the evacuation procedure is truly an UNLOADING PROCEDURE. Such action can draw attention from motorists that you need assistance. District policy should determine if this procedure is appropriate.

4. Be sure your path is CLEAR.

5. Stand with both feet firmly planted, about shoulder width apart for good balance.

6. Always bend from knees, not from back, so that you use your thigh muscles and buttock muscles rather than your back muscles to do the lifting.

7. When lifting and carrying, keep the student as close to your own body as possible.

8. Shift the position of your feet to move. DO NOT TWIST YOUR BODY. Take small steps to turn.

Single Person Lift

1. Follow the basic rules 1-8. Most strains, fatigue, and back injuries caused by lifting are due to using the WRONG muscles. Use your STRONG LEG AND BUTTOCK MUSCLES (by bending at the knees and hips) NOT YOUR BACK MUSCLES. Maintain the normal curves of the spine when lifting and avoid rounding of the upper back. (Keep your back straight)!

2. Keep equal weight on both feet and lower yourself to the level of the student by bending your knees and hips before lifting.

3. Once in position, put one arm around the upper back and the other under both knees.

Two Person Lift

1. Follow basic Rules 1-8.

2. TO LIFT FROM A WHEELCHAIR:

A. Position the wheel chair as close to your destination as possible. In an emergency situation, to save time and congestion, leave the chair where it is strapped and blanket pull or carry the student to the appropriate exit location.

B. One person stands in front to the side, the other in back.

C. The person in front removes the arm rest (if detachable) and folds up the footrest.

D. The person in back removes the seat belt and any other positioning device.

E. The person in front, bending from knees and hips, lowers himself or herself to place one arm under the student's knees and the other under the occupant's thighs.

F. Person in back places his or her arms under student's armpits, reaching forward to grasp both student's wrists firmly. (Your right hand to student's right wrist; left hand to left wrist).

G. Lift together on the count of 3. (REMEMBER TO USE YOUR LEGS AND BUTTOCK MUSCLES TO BEND.)

H. Walk to area where student is to be placed and lower on the count of 3, bending from the knees and hips

3. TO LIFT FROM A BUS SEAT:

A. Use the same procedure as above, but first, SLIDE THE STUDENT TO THE EDGE OF THE BUS SEAT NEAR THE AISLE.

Blanket Lift

1. Fold a blanket in half; place on the floor as close to the child as possible.

2. Follow lifting rules 1-8 and lower the student to the blanket.

3. ONE PERSON LIFT: Place the student's head toward the direction of exit, lift the blanket from head and slide to safety.

To Assist a Person Up Stairs

1. Follow basic rules 1-8.

2. Curl the student up as much as possible. Keep the student's arms and legs from flopping loosely. This flopping could throw you off balance and cause a fall.

3. Support the student's head and neck as you would an infant's.

4. Do not lift students up by an arm or leg except in extreme emergency.

5. Slow rocking or a firm holding will help to relax a very "tense" student.

Basic Body Mechanics

1. Size up load and don't hesitate to ASK for help.

2. Be sure that the passenger knows you are going to lift him/her.

3. Plan ahead: How you will lift and where you are going.

4. Bend your knees and hips instead of your back. Keep your back straight. Maintain the normal curves of the spine as lifting.

5. Keep your feet apart while lifting to give a broad base of support.

6. Keep the person CLOSE to you.

7. If lifting with someone else, lift smoothly and together. Count 1,2,3.

8. Take small steps. Never twist your body while lifting or carrying.

SAMPLE CONTINUUM
OF TRANSPORTATION SERVICES FOR STUDENTS WITH DISABILITIES
(CHOICE OF OPTION THAT MAY BE AVAILABLE AS APPROPRIATE)

Least Restrictive

Most Restrictive

	public transit use varies					Parent/guardian to provide their own child's transportation with district reimbursement								
student walks to school alone or with peers	student uses public transit one way	student combines school bus with public transit	student uses public transit both ways	student rides school bus possibly with modification or lift	student rides school bus w/ support network w/ w/o adaptive equipment	student rides public transp with support network	student rides integrated school bus w/ support network w/ w/o adaptive equipment	student rides modified bus w/ students with disabilities w/ w/o adaptive equipment	student rides modified bus w/ attendant w/ w/o adaptive equipment	student rides modified bus w/ attendant and/or nurse w/ special training possibly w/ limited ride time possibly w/specially equp'd vehicle possibly w/intervention	student needs specialized pick up or bus ride ALONE w/ attendant	student needs specialized bus ride w/ specialized attendant	student needs bus alternative for out of town travel	transportation inappropriate for student (may be eligible for home/hospital teacher)
USE CORNER BUS STOPS OR SCHOOL PICK UP SITES							HOME PICK UP OR HOME CORNER PICK UP					HOME OR INSTITUTIONAL PICK UP		

Form 4

D. STUDENT TRANSPORTATION CARD – SPECIAL NEEDS STUDENTS

Students Name: ________________ Date: ______ Address: ________________

________________ Home Phone: ________ Father's Work Phone: ____________

Mother's Work Phone: ________ Emergency Phone: _____ Please check appropriate type of transportation for your child:

☐ Walks to bus unassisted
☐ Requires a car seat
☐ Needs to be carried
☐ Booster seat
☐ Special Equipment
☐ Walks to bus, but needs assist.
☐ Wheelchair
☐ Requires Special Restraint
☐ Positioning Devices
☐ Requires Attendant

Needs to be met at school? ________________ Other (Specify) ____________

________________ On return/home, needs to be met at Bus Stop? ____________

Names & Addresses of persons nearby student's residence who have consented to care for the student if the parents are not available:

Name: ________________ Address: ____________ Phone: ____________

Name: ________________ Address: ____________ Phone: ____________

Name: ________________ Address: ____________ Phone: ____________

Please check if any of the following applies to your child:

☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ Blind ☐ Deaf

☐ Chronic Respiratory Problems ☐ Non-Verbal ☐ Bee Sting ☐ Hemophiliac

☐ Allergies–to what?

____

Seizures: How long does seizure last? ____________ How often do they occur? ______

Action needed, if any ________________________ Is your child on medication? ☐ Yes ☐ No If yes, what medication, what dosage, and when given?

____________ Family Doctor: ________________ Address: ____________

________________ Doctor's Phone Number: ________________

Family Designated Hospital: ________________ **Parental Contact:** If possible and practical, in the event of major emergency, parent contact will be made.

Parental Approval: If in the opinion of the driver a major emergency exists, the parent(s) have agreed in writing and will assume the cost of:

1. Contacting the family doctor ☐ Yes ☐ No
2. Contacting any doctor available ☐ Yes ☐ No
3. Contacting rescue squad ☐ Yes ☐ No
4. Transporting to designated hospital ☐ Yes ☐ No

Other Helpful Information: ____

____ As parent or guardian, I agree to one or more of the above procedures as indicated and agree that this information may be shared with my child's transporter. CONFIDENTIALITY WILL BE MAINTAINED

Date: __________

Parent or Guardian's Signature ______________________

DO NOT WRITE BELOW THIS LINE

____

Bus Company ________________________________

Bus No. ______ Telephone ______________________

Special Instructions for Driver ______________________

____

____________________SCHOOL DISTRICT

____
____
(Address)

TRANSPORTATION SERVICE REQUIREMENTS FOR PASSENGERS WITH HEALTH CONCERNS

DATE:____________________ ASSIGNED SCHOOL:____________________
GRADE LEVEL:______________ SPECIFIC PROGRAM:____________________
HOME SCHOOL:____
NAME OF STUDENT:____
BIRTH DATE:____________________ STUDENT I.D. #____________________
HOME ADDRESS:______________________________ ZIP:______________
HOME PHONE:____
A.M. PICK-UP LOCATION:____________________PHONE:______________
P.M. DROP-OFF LOCATION:____________________PHONE:______________
PARENT(S) NAME:____
FATHER'S WORK PHONE:______________MOTHER'S WORK PHONE:______________

EMERGENCY / ALTERNATE CONTACT:
Name:____________________Phone:____________________
Address:____
Name:____________________Phone:____________________
Address:____

EMERGENCY MEDICAL INFORMATION:
Student's Doctor:____________________Phone:____________________
Hospital Preference:____
Address:____

ALLERGIES:____
MEDICATION STUDENT IS UNDER:______________________________
DOSAGE:____
SPECIAL INSTRUCTIONS FOR ATTENDING PHYSICIAN (S):______________
____
____
____

SPECIFIC INSTRUCTIONS IF PARENT (S) ARE NOT AT HOME:______________
____
____

LEVEL OF SUPERVISION REQUIRED (attach Medical Procedure Authorization and procedure):____

REQUIRED TRAINING FOR SUPERVISION:______________________________

INTERVENTIONS REQUIRED (attach Medical Procedure Authorization and procedures):______

REQUIRED TRAINING FOR INTERVENTIONS:______________________________

OTHER ADDITIONAL RESTRICTIONS OR MODIFICATIONS NECESSARY TO TRANSPORT STUDENT:______________________________

DISABILITY CONDITIONS AFFECTING TRANSPORTATION:______________________________

SPECIAL EQUIPMENT, AIDS, OR MOBILITY ASSISTANCE REQUIRED:______________

ADDITIONAL COMMENTS / INSTRUCTIONS:______________________________

PROCEDURE IF CHANGE IN SERVICES NECESSARY: If there are any changes in the student's health, medical or behavior status which the parent(s), physician, transportation, or other school staff believe may merit changes in staffing, precautions to be taken, interventions, restraints, or any other procedure noted above, the concerned party shall immediately contact ____________________ (Phone:____________________) who will in turn initiate the process to evaluate and recommend necessary changes with the involvement of parents(s), physician, school, and transportation staff

APPROVAL OF TRANSPORTATION SERVICE REQUIREMENTS: Each of the following persons has participated in the development of these transportation service requirements and by signing below approves them for implementation.

Dated:____________________ ____
Signature of Parent / Guardian

Dated:____________________ ____
Signature of School District Representative

Dated:____________________ ____
Signature of Transportation Staff Representative

Dated:____________________ ____
*Signature of Private Contracted Transporter

Dated:____________________ ____
*Signature of School Nurse

Dated:____________________ ____
*Signature of Physician

*If an appropriate signature under the circumstances.

cc: All transportation Service Providers

AMERICAN
FEDERATION OF
TEACHERS
AFL•CIO

555 NEW JERSEY AVENUE, NW
WASHINGTON, DC 20001-2079

ASK FOR ITEM NO. 451-a
5/97